United States v. State of Texas

Monitoring Team Report

Rio Grande State Center
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Introduction

Background

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

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

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

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

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

Methodology

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

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

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

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

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

Organization of Report

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

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

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

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 Team greatly appreciates all this assistance from staff throughout the Facility. The Monitoring Team was especially appreciative of the efforts of the Settlement Agreement Coordinator, Mary Ramos, and the staff who assisted her to keep up with all our requests. They ensured the documents requested were available before, during, and after the visit. They coordinated arrangements for all the meetings and observations.

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

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

Given the issues that were identified during baseline and earlier compliance reviews, it was expected that the change processes would take time. As the findings in this report illustrate, it was clear that the Facility had taken a number of steps to address identified issues and to comply with the Settlement Agreement. In a number of areas, progress had been made. In other areas, the foundation had been laid for change. In some areas, concerted efforts need to be made over the next six months to make essential improvements. The following report provides brief highlights of areas in which the Facility is doing well or had made significant improvements and other areas in which improvements are needed.

General Comments

Population. Population of the Facility at the beginning of the compliance visit was 71.

Facility Self-Assessment. The Self-Assessment and Plan of Improvement could be revised to be more effective at both assessing and reporting status and at doing and documenting effective planning to meet the requirements of the Settlement Agreement. For the most part, the current POI simply reported on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. The POI did not provide details as to the Facility's self-

assessment processes, but rather listed some actions the Facility had taken since the last visit. The POI should describe, in addition to the self-rating of compliance:

- The activities the Facility engaged in to conduct the self-assessment of the provision. This might include sampling, observations, implementation of their self-assessment tools, etc.
- How the Facility used the findings from these activities to determine substantial compliance or noncompliance.

Separately in each Section of the POI, the Facility also provided a list of action steps to be done. Some of these steps build on each other and were presented in an appropriate order. Others were simply additional tasks to be done. It would be helpful if the Facility were to plan actions to accomplish specific goals and requirements, and present them in a way that shows an organized approach that can be tracked. These, along with measures of outcome, could provide the framework for reports of status. The Facility should consider how it might use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes.

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

Restraints
Status: RGSC continued to make progress towards full compliance with this section of the Settlement Agreement, especially in regard to low frequency of use of restraint in crisis intervention and dental pre-treatment sedation, and improvements in documentation of crisis intervention restraints.

- Positive Practices and Improvements Made
  - Frequency of crisis intervention is low and continuing to trend down. No individuals were restrained more than three times in a 30-day period.
  - Documentation related to the few crisis intervention restraints was much improved from that observed in the last review. Progress in documentation related to medical restraints had also improved but not as dramatically as that observed with respect to crisis intervention restraints.
  - Pre-treatment sedation for dental procedures accounted for only 16% of medical restraint. This validates the success the Facility has had in supporting individuals in the provision of dental care. The administrative initiatives noted in the last compliance report to support individuals in dental and medical appointments remained in place and appear to be achieving the desired results.
  - The Facility has been using the 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.
- Improvements Needed

- Restraint records reviewed by the Monitoring Team did not contain physician orders with sufficient specificity to comply with this RGSC policy requirement or physician face-to-face assessments with sufficient specificity to comply with this RGSC policy requirement. If the Facility retains these policies, it must ensure they are followed.
- Release codes need to be documented accurately in restraint documentation.
- Although progress had been made in addressing pre-treatment sedation, especially for dental services, there were still examples in which programs to minimize use of pre-treatment sedation and medical restraint were lacking.

Abuse, Neglect and Incident Management

Status: The systems for abuse/neglect reporting and the incident management system at RGSC have improved since the last compliance review.

- Positive Practices and Improvements Made
  - Facility policies had been reviewed and revised to include SA requirements previously missing.
  - The IMRT process appears to be functioning well. Improvements from the last compliance report were evident.
  - 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.
- Improvements Needed
  - Improvement is needed in the timely reporting of incidents and the timely commencement of investigations. The internal management and monitoring systems in place at RGSC are self-identifying most instances of noncompliance but additional work is needed to reduce frequency.
  - Late reporting suggests staff knowledge needs to improve. The Facility had established a system of competency checks that focus on reporting to DFPS. The Facility may need to expand these competency checks to ensure staff have more in-depth knowledge of activities and events that represent reportable incidents.
  - 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 recorded on trend reports continues to need improvement, most notably in the separate categorization of incidents investigated by DFPS.

Quality Assurance

Status: The Facility had initiated many of the administrative activities that will be necessary to achieve compliance with this section of the SA. The Monitoring Team observed improvements in the QA process from that noted in the last compliance report.

- Positive Practices and Improvements Made

- The Facility implemented the use of the Statewide Monitoring Tools Database with findings reported to the SA-PIC; developed a strategy to better analyze data, referred to as CATW^2 , Check, Ask, Think, Why, and What; assigned quality advisors for each SA section team and began training teams/committees on CATW^2 ; used CATW^2 to analyze Trend Analysis Reports; updated the Corrective Action Plan (CAP) form to include date CAP initiated, monitoring frequency and type of evidence to be submitted; initiated a monthly report for SA-PIC of CAPs initiated and CAPs completed; and, developed a QA plan which includes who, or which SA section team, initiates a CAP and which team monitors the completion of the CAP.
- Data reports are better organized and labeled. A system for corrective action plans and the tracking of their implementation is in place.
- The Facility had developed a written Quality Assurance Policy and Plan. The Plan is comprehensive and ample evidence exists that demonstrates the plan is being implemented. Many CAP's resulted from plan implementation. These CAPS were tracked and not closed until evidence was collected and provided to the QA Department to validate completion. The process for data analysis was improved from that observed at the last compliance review.
- The Facility developed a simple straightforward approach to guide different work teams in their analysis of report data. This process requires review teams to check (C) the data, ask (A) questions about what the data is suggesting, think (T) about opportunities for improvement, talk about why (W) we are contemplating certain corrective action (in the context of the data), and what (W) can be done about it. This process was regularly used, documented on a special form, and referred to as CATW^2.

- Improvements Needed
  - The system for corrective action plans needs to include a focus on systemic trends requiring organizational change response.
  - The QA activity in place at RGSC consisted largely of administrative steps directed at a strategy of developing actions to correct specific problems discovered through monitoring and auditing. While this is important, there is also a need for development of broader strategic action plans to correct systemic problems identified through the analysis of data collected over time from a variety of sources.

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

Status: Although RGSC had implemented the PSP process established by the state and had demonstrated improved interdisciplinary discussion, integrated planning was not yet routine, individualized programs were not well-integrated in the PSP, and data were not regularly used for decisions. There was variability in the timeliness and comprehensiveness of assessments.

- Positive Practices and Improvements Made
  - A PSP was developed for each individual.
  - RGSC implemented the new PSP process established by the state.

- There was improvement in interdisciplinary discussion, including direct service staff, during planning and review meetings.

- Improvements Needed
  - The new PSP process did not yet produce integrated planning.
  - Although the discussion at PSP planning and review meetings 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.
  - There was variability in the quality and comprehensiveness of assessments. Assessments must meet current standards for content and must be thorough.
  - Assessments must be completed more regularly when an individual has a change in health or behavioral status.
  - Review of structural and functional assessments revealed improvement but not yet compliance.
  - The Facility did not address obstacles to movement to a more integrated environment adequately. Obstacles were identified that could be made available by other providers, and strategies to overcome obstacles were not addressed in many PSPs.
  - Although 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.

<u>Integrated Clinical Services</u>
Status: Although there had been improvements in interdisciplinary discussion, services were not yet well integrated. during planning meetings,

- Positive Practices and Improvements Made
  - Integrated discussion during planning and review meetings had improved.
- Improvements Needed
  - Planning remained multidisciplinary.
  - The Medical Care policy had been revised to add expectations for integration of medical care into the PSP but still fell short of full integration.
  - Although there was documentation that Facility clinicians reviewed and agreed with reports and recommendations from non-Facility clinicians, there was at times a lack of follow-up assessment that should have occurred. Furthermore, there was not routine documentation that the PST was notified of results and recommendations and involved in planning when appropriate.

<u>Minimum Common Elements of Clinical Care</u>

Status: The Facility was in process of developing clinical indicators that could be used in a system to monitor health status. Assessments were not consistently timely and comprehensive.

- Positive Practices and Improvements Made
  - The Facility had begun to develop clinical indicators that could be used in a system to monitor health status.
  - Diagnoses were consistent with current standards, and that they clinically fit diagnostic assessments.
- Improvements Needed
  - Assessments were not consistently provided timely on a routine basis or in response to changes in health or behavioral status. Furthermore, assessments were not consistently comprehensive.
  - Interventions were not always implemented or revised timely based on either assessments or clinical indicators.

<u>At-Risk Individuals</u>
Status: Although RGSC had implemented a new At-Risk identification process, much work remains to ensure accurate ratings of risk and appropriate responses when risks are identified. The RGSC processes to demonstrate compliance with this section of the SA were insufficiently organized to enable a comprehensive review.

- Positive Practices and Improvements Made
  - The statewide risk risk assessment procedure, with improved guidelines for rating risk, had been initiated.
- Improvements Needed
  - Risk levels assigned to individuals were not consistently accurate.
  - Risk assessment documents frequently could not be located and/or were not integrated into the PSP.
  - Risk assessments were often not conducted within five working days of risk identification or a change in circumstances.
  - Assessments were not sufficiently comprehensive to enable interdisciplinary discussion and accurate determination of risk.
  - Lack of timely identification of risk prevented the development of timely and appropriate risk mitigation plans.

<u>Psychiatric Care and Services</u>
Status: Quantity and quality of psychiatric staff was adequate. Improvements had been made in screening, evaluation, and diagnosis. Integration with other PST disciplines, including behavioral services, needs improvement.

- Positive Practices and Improvements Made
  - Psychotropic medications are not used for staff convenience or as a means of punishment.
  - The Facility has a process to screen all new admissions with the Reiss Screen, and all individuals at the Facility have been screened using the Reiss Screen.

- Improvements Needed
    - Data analysis was not considered prior to prescribing psychotropic medications, and not considered when developing a psychiatric case formulation.
    - The Facility must enhance its review of all pre-treatment sedation use at the Facility.
    - The psychiatrist should participate in the PST process and in development of Positive Behavior Support Plans (PBSPs).
    - The Facility had yet to complete a comprehensive review of polypharmacy and provided only limited review of those discussed at the polypharmacy meeting. The Facility did not have a comprehensive policy or operating procedures for the polypharmacy committee. The Facility did not consider the combination of a first generation and a second generation antipsychotic as polypharmacy. , The Polypharmacy Committee offered only minimal recommendations and action plans.
    - RGSC does not appropriately complete side effect assessments, provide more frequent side effect monitoring when clinically appropriate, and ensure that there is an effective system in place to respond to side effects of psychotropic medications.

<u>Psychological services</u>

Status: The Psychology Director, who has experience in applied behavior analysis, has worked hard to improve behavioral services. However, turnover and the lack of staff has made it difficult to develop treatments and interventions and to ensure they are implemented.

- Positive Practices and Improvements Made
    - The Director of Psychology had extensive experience in behavior analysis.
- Improvements Needed
    - PBSPs and other formal and informal interventions were not routinely or accurately implemented. In some circumstances, staff were observed to not intervene when conditions met the requirement for intervention in the PBSP.
    - The Monitoring Team did not observe collection of behavioral data, and documents revealed numerous errors in data.
    - RGSC continued to experience limitations in reviewing the quality of PBSPs. RGSC had arranged for external peer review of PBSPs. An audit of PBSPs recently subject to external peer review, however, revealed the external review process to provide minimal input from the reviewer.
    - Records for several individuals with challenging behaviors and/or mental illness reflected that treatment decisions were often not based upon available data, including failures to revise ineffective PBSPs and changes in psychotropic medications that were not supported by assessments or treatment data.

Medical Care

Status: The Monitoring Team clearly noted improvements in the area of addressing acute care medical problems, and addressing follow-up of many consultations and diagnostic reports. The newly hired primary care physician had just begun his assessment of chronic care issues of Individuals served by the Facility. Nevertheless, there were still concerns about assessment and response to chronic conditions and changes in health status, as well as with integration of health and medical services into the PSP process.

- Positive Practices and Improvements Made
  - There were improvements in the way the Facility addresses acute medical problems.
  - Improvement had occurred in follow up of consultations and diagnostic reports.
  - The Facility hired a new physician.
- Improvements Needed
  - Chronic care issues required more assertive management.
  - The Facility had yet to implement the DADS State Office policy on focus case reviews.
  - The Facility had yet to begin developing a process to collect, and analyze data for quality improvement of medical services at the Facility.

Nursing Care

Status: Improvements had been made in many aspects of nursing care. These included assessment and documentation, infection control, and training direct care staff. Nevertheless, much improvement was still needed in areas such as assessment, risk screening, and administering medications.

- Positive Practices and Improvements Made
  - Assessment and documentation of individuals' acute changes in status, and more consistent use of the SOAP format for documentation.
  - The NOO/Hospital Liaison consistently visits individuals in the hospital and reported findings in the Integrated Progress Notes, as well as in the shared drive, to keep the physician and relevant team members apprised of individuals' status.
  - The nursing staff were improving the assessment of pain and documenting individuals' response to per needed (PRN) medication.
  - The 10-6 shift RN was completing 24-hour chart checks to ensure Physician Order's were transcribed.
  - The Medical and Dental Appointment Database continued to improve by adding the reason for missed appointments in order to track and trend missed appointments.
  - The Infection Control Preventionist Nurse had completed 100% of preventative health and immunization records and had a compliance rate of 97.86%.

- A review of the Hand Hygiene and Environmental Surveillance Reports found evidence that when deficiencies were identified plans of correction were implemented and followed through to resolution.
- The emergency response system demonstrated improvement by placing emergency equipment in the Vocational Services area for ready access. There was evidence that Mock Medical Emergency Drills were scheduled and completed according to policy. There was documented evidence when drills were failed that "on the spot" corrective action was taken and if that was not effective individuals were sent for re-training.
- Since the last review the nursing staff were providing training to the direct care professionals on care plans as opposed to giving the care plans to the home manager or supervisors to provide the training. The nursing staff had developed special instruction sheets derived from care plans to put in the Me Books for the direct care staff to use as reference.
- The Nursing Department continued to maintain an excellent Nursing Training and Tracking Database, which included the names of the topics taught, number of nurses trained on each topic, percentage of total nurses that received training on each topic, and the projected completion date for each topic.
- The timeliness of correcting and investigating medication errors had improved.

- Improvements Needed
  - The Nursing quality assurance system was still evolving. Few of the Nursing Care Monitoring Tools had been completed. There was inadequate data available to determine compliance.
  - Since the last review some improvement was found in the Annual and Quarterly Comprehensive Nursing Assessments in Sections I through X. The Nurse Case Managers were still struggling with how to adequately summarize individuals' nursing problems/diagnoses to describe individuals' progress toward established goals and objectives. The Nurse Case Managers need additional training on how to summarize nursing problems/diagnoses to adequately assess individuals' progress toward meeting their established goals and objectives and to assess the effectiveness of their plans of care.
  - Nursing staff had not been trained on all of the State nursing policies, procedures, processes, and protocols. Neither had training begun using the Nursing Education Handbook Manual.
  - The nursing staff needs to exercise clinical judgment and critical thinking in addition to the policy guidelines when rating risk levels.
  - Since the last review a schedule for Medication Administration Observation had been developed and implemented. There was no documentation supplied for review that validated that the scheduled observations had occurred or that observation data were analyzed, trended, and plans of correction developed, implemented, and followed through to resolution. During medication administration observations completed on site, several problems were identified.

<u>Pharmacy Services and Safe Medication Practices</u>
Status: Since its last review, the Monitoring Team noted no improvements in the area of pharmacy services.

- Positive Practices and Improvements Made
    - The Facility's Drug Utilization process provided some information to providers regarding prescribing habits for selected medications.
    - The updated DADS Policy for Medication Errors contained the essential elements of a Medication Variance Process, and if implemented would help enable the Facility's compliance with Provision N.8. The Facility intends on adopting the new policy in the near future.
- Improvements Needed
    - The Facility had an ineffective mechanism to ensure that pharmacists appropriately review medication orders, and to ensure that each order is associated with a clinically rational diagnosis and appropriate dosage range; that side effects and allergies are addressed; and that necessary laboratory testing is accomplished.
    - The Facility did not have a comprehensive system in place that enables collaboration between the pharmacist and prescribing medical practitioners when addressing STAT medications, benzodiazepines, anticholinergics and polypharmacy.
    - The Facility must develop a consistent and functional process that ensures physicians address pharmacists' recommendations, establish a protocol to follow when physicians and pharmacists do not concur on a clinical issue, establish a mechanism to document collaboration between pharmacists and physicians, and ensure that recommendations are followed-up to resolution.
    - MOSES and DISCUS assessments were not completed as required, and more frequent monitoring for Tardive Dyskinesia (TD) was not assessed when clinically indicated.
    - The Facility's policy for ADRs was not adhered to, and the ADR forms were not completed as required. There was no meaningful review process for ADRs.

<u>Physical and Nutritional Management</u>

Status: There had not been significant improvement in the process of developing, implementing, or monitoring physical and nutritional management plans and interventions. Assignment of a PNM nurse should help, but this might require additional time in addition to the time assigned.

- Positive Practices and Improvements Made
    - A PNM nurse was assigned 20 hours per week.
    - Progress was also noted regarding to the development of a PNMT evaluation. The template was reviewed by the Monitoring Team and had the potential to serve the team well by providing detailed information regarding the individuals' total PNM status.

- Improvements Needed
    - 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 in a timely manner 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 and implemented; however, lack of use of clinical judgment and critical thinking when the PSTs had to move beyond the policy guidelines often resulted in inaccurate assignment of risk.
    - Individuals were not provided with comprehensive assessments in response to changes in status or as part of an annual assessment due to often referring to outdated tests and external assessments.
    - Supports regarding the areas of oral care and medication administration were missing from the assessment process and were not comprehensively included in the PNMP.
    - 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.
    - 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.
    - Not all individuals receiving enteral feeding received 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.

<u>Physical and Occupational Therapy</u>
Status: Although some improvement had occurred, there was still a need for much more. Interventions, other than PNMPs, were not provided consistently.

- Positive Practices and Improvements Made
    - The Habilitation Department was working to open a sensory room, calming room as well as a gym. The gym will assist in the development of more proactive programs to maintain and improve upper and lower extremity functioning.
- Improvements Needed
    - 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 and were not comprehensive.
    - Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. Other than the limited evidence of direct intervention, the primary support provided was via the PNMPs. Plans were not implemented as written and staff were not knowledgeable of the OT/PT plans.

- Intervention plans related to positioning, oral care, and medication administration were not based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies.
- Therapy services were not consistently integrated into the PSP.
- The system to monitor implementation of plans needed improvement.

Dental Services

Status: The Facility made significant improvement in the area of dental services, including oral hygiene.

- Positive Practices and Improvements Made
  - The Facility has contracted with a dental hygienist, who is working to improve oral hygiene.
  - The Facility has implemented a much-improved scheduling system that will enable better tracking of dental services.
- Improvements Needed
  - Although the scheduling system has improved, the Facility must improve on missed dental appointments.
  - Although there is now a program in place to improve oral hygiene, the Facility must ensure it is effective and must enhance the ability of direct care staff to provide oral hygiene, and establish a meaningful suction tooth-brushing program..
  - The PSP process was ineffective in monitoring dental health care issues, addressing desensitization programs, and addressing the use of pre-treatment sedation, TIVA, and general sedation.

Communication

Status: There has not been significant progress in Communication services, although there had been expansion in exposure of individuals to adaptive and alternative communication (AAC). The current ratio for Speech Pathologist to clients was approximately 1 to 73 and will need to be enhanced to permit participation in all facets of care and monitoring.

- Positive Practices and Improvements Made
  - Individuals were beginning to be exposed to AAC through the use of individual and shared devices
- Improvements Needed
  - The Communication Assessment did not consistently address expansion of current abilities and development of new skills.
  - AAC devices were not consistently available, utilized, portable and functional in a variety of settings.
  - Direct Care Professionals (DCPs] interviewed were not knowledgeable of the communication programs.
  - There was no monitoring of communication devices or integration of communication programs and strategies into the PSP.

Habilitation, Training, Education, and Skill Acquisition Programs

Status: There had not been significant progress in the development of skill acquisition or in active engagement of individuals throughout the day.

- Positive Practices and Improvements Made
  - It was observed that the vocational program at RGSC involved a substantial amount of functional activity, primarily in the form of formal jobs relating to vocational contracts. This level of active treatment was very positive.
- Improvements Needed
  - Individuals observed were not routinely engaged in a meaningful activity.
  - There was a lack of formal tracking systems for participation in training activities.
  - Records relating to community activities consisted of handwritten tallies and unorganized Transportation Checklists.

Most Integrated Setting

Status: The Facility had not yet improved adequately in using the PSP process to identify needed supports and develop CLDPs based through PST involvement. The Facility had continued to improve both its process to refer individuals for movement and to monitor provision of identified supports through the transition period.

- Positive Practices and Improvements Made
  - Although only one person had moved since the last compliance visit, the Facility had made significant progress in increasing the number of individuals referred for movement to a more integrated setting.
  - It was positive to find that the PSP annual planning meeting observed during the visit began with a focus on whether the individual was interested in moving to a more integrated setting and included thorough and integrated discussion of the supports that would be needed for transition.
  - The Facility had established a pre-move site visit process to ensure essential supports are in place at the time of a move.
  - Post-move monitoring visits were thorough and timely.
  - One individual was transferred to an SSLC. CMS-required discharge planning processes were carried out.
- Improvements Needed
  - The Facility still needed to continue expanding its actions to encourage individuals to move to a more integrated setting.
  - The format of PSPs reviewed by the Monitoring Team made it difficult to determine what was specified as supports and services needed to move to a more integrated environment versus supports currently being provided or suggested for provision at RGSC. Furthermore, obstacles to movement were listed that could and should routinely

be made available by other providers in community settings, and strategies to overcome obstacles were not consistently addressed.
    - The Facility had not yet completed assessments of all individuals for placement. Professional members of the PST had not documented determinations of appropriateness of community living nor were recommendations routinely found in assessments.
    - Supports listed in the CLDP were determined by the APC based on review of the assessments and of the PST discussion. The PST should be responsible for identification of the supports.

Consent

Status: RGSC had revised criteria used for rating priority and had revised rankings based on those criteria.

- Positive Practices and Improvements Made
    - 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.
    - Guardians had been obtained for one newly admitted individual and three individuals whose guardianships had lapsed.
- Improvements Needed
    - DADS had drafted a policy on guardianship but had not completed or implemented it.
    - Although 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.
    - Although the HRO was making attempts to find resources for guardianships, there will be a need for a structured and active recruitment program once the statewide policy is implemented.

Recordkeeping and General Plan Implementation

Status: The Monitoring Team found improvement moving toward compliance in each provision. The Unified Record was in place, and there was a system to audit records.

- Positive Practices and Improvements Made
    - The Unified Record was in place and was generally organized so that documents could be found and used.
    - An audit system was in place to review the Active Record and to identify and track completion of Corrective Action Plans (CAPs). Both individual and systemic actions have been implemented based on information from these audits.
    - The Facility had recently initiated a survey process to assess use of the records in making decisions. The Facility did not yet include a broader process, although data were available that could be used in a more comprehensive review.
- Improvements Needed

- Documents in the record were not always current, and assessments were not completed and posted in a timely manner.
- The audit system did not review the Individual Notebook, nor did it include all requirements of Appendix D of the SA.
- There was no evidence of a process to ensure that the data from the audits were accurate, such as an interobserver agreement process; agreement between the Monitoring Team and the Facility on one sampled record was in an acceptable range, but the Facility needs its own system to ensure continuing accuracy of audits.
- Policies necessary to implement all requirements of Part II of the SA were being developed, revised, and implemented but some remained to be developed.
- Observations at meetings indicated that the records were often referred to; nevertheless, much information at the meetings involved reporting of impressions rather than data or other objective information from the record.

Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement (POI) 8/9/11 2. DADS Policy 001-Use of Restraint 8/31/09 3. RGSC SOP MR 700-14 The Use of Restraint (4/11) 4. RGSC SOP MR 200-02 Restrictive Practices (6/11) 5. Crisis intervention restraint records for Individuals #61, #62, # 139, # 151, and #122(2x) 6. Medical restraint records for Individuals #3, #31. #36, #62, #91, #93, #108, and #145 7. Individual Supports for Medical/Dental Appointment plans for Individuals #35, #45, #61, and #101 8. Facility specific training material labeled "PNA/Rehab Tech Competency Check," "Restraint Monitor Competency Check," "Clinically Competent Nurse Competency Check," and "Personal Support Team Competency Check" 9. Restraint monitor competency checks for sample of restraint monitors 10. Restraint Log 3/1/11 to 7/30/11 11. Restraint Trend Analysis through June, 2011 12. Training transcripts for sample of staff 13. Personal Support Plan (PSP) and Positive Behavior Support Plan (PBSP) for Individuals #15, #61, #122, and #139 **People Interviewed:** 1. Lorraine Hinrichs, ICF-MR Program Director 2. Mary Ramos, Quality Management Director 3. Alondra Machado, Data Analyst 4. Megan Gianotti, Psychology Manager 5. Myrna Wolfe, Incident Management Coordinator 6. Janie Villa, QMRP Manager 7. Eight Direct Support staff **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 8/22/11 *2.* Settlement Agreement Performance Improvement Council (SA-PIC) 8/24/11 *3.* Personal Support Plan (PSP) meeting for Individual #140 on 8/25/11 4. Quarterly PSP Review meeting for Individuals #40 and #74
	Facility Self-Assessment: The RGSC POI reported that the Facility was not in substantial compliance with five of seven provisions of this section of the Settlement Agreement (SA). The eighth provision (C.7) was not rated because RGSC did not have any individuals who were restrained with sufficient frequency to trigger the requirements of the provision.

	The Monitoring Team did not find the RGSC in compliance with any provision of this section of the SA. This is primarily due to one restraint (of six) where the documentation provided to the Monitoring Team was confusing and the Monitoring Team could not reliably ascertain the sequence of events or circumstances associated with this restraint, whether the restraint episode was medical or crisis intervention, or both, and whether or not relevant policies were followed. The Facility's process for self-assessment of this section of the SA consisted primarily of 100% review of restraint episodes and related documentation by the Psychology Manager. RGSC had 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 frequency of restraint use at RGSC was low allowing the Psychology Manager to personally review each crisis intervention restraint and each medical restraint. 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. The self-assessment process used at RGSC had been effective in identifying issues that need attention in order to achieve full compliance with the SA.
	Summary of Monitor's Assessment: RGSC continued to make progress towards full compliance with this section of the Settlement Agreement, especially in regard to use of restraint in crisis intervention and dental pre-treatment sedation. With the exception of one crisis intervention restraint (of six) where the documentation provided to the Monitoring Team was confusing and the Monitoring Team could not reliably ascertain the sequence of events or circumstances associated with this restraint, the Monitoring Team was able to observe improvement in practices and documentation. Because the frequency of crisis intervention is low the documentation associated with this one restraint precluded a determination of substantial compliance in several provisions of the SA. Crisis intervention restraint use at RGSC continued to trend down. RGSC used restraint for crisis intervention only six times since the last compliance review. In the prior review period crisis intervention restraint was used eight times. A significant part of crisis intervention restraint documentation issues in this report relate to one restraint episode for which the documentation presented to the Monitoring Team was disjointed and confusing. Documentation related to the other five restraints was much improved from that observed in the last review. Progress in documentation related to medical restraints had also improved but not as dramatically as that observed with respect to crisis intervention restraints. Restraint use at RGSC, which was noted to have decreased significantly in the last review, continues to remain low. This is the case with both crisis intervention and medical restraints. The frequency of use of pre-treatment sedation remained low. Although the average number of medical restraints per month had increased slightly, from eight per month in the six months preceding the last review, to nine per month since the last review, most pretreatment sedation (84%) was for medical procedures. Pre-treatment

	sedation for dental procedures accounted for only 16% of medical restraint. This validates the success the Facility has had in supporting individuals in the provision of dental care. The administrative initiatives noted in the last compliance report to support individuals in dental and medical appointments remained in place and appear to be achieving the desired results. This was most noticeable in the detailed plans that are developed for an Individual preceding a scheduled community medical or dental appointment. These plans identified 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 Facility has been using the 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. This has contributed to a set of practices that are moving RGSC closer to compliance with this section of the SA. The Facility reported that its internal monitoring found instances where the Personal Support Team did not review the need for medical restraint and establish supports to minimize the need for restraint.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an 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 29 of 38 (76%) instances of medical restraint where the Personal Support Team (PST), contrary to policy, did not review the need for medical restraint and establish supports for the individual that minimize the need for restraint. The Monitoring Team concurs with this self-assessment. RGSC SOP ICFMR 700-14, The Use of Restraint (4/11) 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. Crisis intervention restraint use at RGSC continued to trend down. RGSC used restraint for crisis intervention only six times since the last compliance review. In the prior review period crisis intervention restraint was used eight times. Rather than take a sample of the six crisis intervention restraints (involving five individuals) the Monitoring Team chose to review all six restraint episodes. This will be referred to as Sample C.1 throughout this report. The Monitoring Team requested (pre-site visit) that documentation files be prepared for each instance of restraint that included at least the following: • Medical Restraints – the restraint checklist, face to face debriefing documents, medical orders, physician specified monitoring schedule, standard facility	Noncompliance

#	Provision	Assessment of Status	Compliance
		protocol for monitoring medical restraint (if applicable), PSP information regarding the development and implementation of plans to minimize the use of medical restraint for the individual, including completed data sheets if a program was developed and implemented, documentation of review activity of the restraint episode, and any other information that would be helpful to the monitor in understanding the circumstances associated with the restraint use. • Chemical Restraint – the restraint checklist, face to face debriefing documents, medical orders, physician specified monitoring schedule, standard facility protocol for monitoring chemical restraint (if applicable), documentation of review activity of the restraint episode, and any other information that would be helpful to the monitor in understanding the circumstances associated with the restraint use. • Physical Restraint -the restraint checklist, face to face debriefing documents, medical orders, standard facility protocol for monitoring physical restraint (if applicable), documentation of review activity of the restraint episode, and any other information that would be helpful to the monitor in understanding the circumstances associated with the restraint use. None of the individuals living at the RGSC had Safety Plans for Crisis Intervention (SPCI). <u>Prone Restraint</u> Based on Facility policy review, prone restraint is prohibited. Based on review of restraint records, restraint reduction committee minutes, staff interviews, 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. The Monitoring Team interviewed eight 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. The Monitoring Team posed the following question: "have you ever been involved in a restraint technique that called for the Individual to lay on their back or stomach? Describe." All eight staff interviewed responded that this was a prohibited practice and they personally had not done such a procedure nor were they aware of such a procedure ever occurring. <u>Other Restraint Requirements</u> 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.	

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		Restraint records were reviewed for Sample C.1 that included the restraint checklists, face-to-face assessment forms, debriefing forms, Personal Support Plan Addendums (PSPAs). IMRT minutes, and any other documents the Facility chose to provide to demonstrate compliance with the SA. The following are the results of this review: In five of six restraint records reviewed (83%), 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." The documentation provided to the Monitoring Team for restraint of Individual #139 (3/14/11) was unclear. The Restraint Checklist described a medical restraint occurring at 1:30pm. The Face-to-Face Assessment/Debriefing (FFAD) described a physical restraint occurring at 10:35am. The computer generated "MR Restraint" record described a physical restraint occurring at 10:35am stating the Individual "started banging head on window in van and attempted to hit staff on way back home." The Restraint Checklist did not provide any information relative to the physical restraint. The FFAD did not provide any information relative to the medical restraint. The Personal Support Plan Addendum (PSPA) from 3/14/11 described a medical restraint prior to an eye exam. The Personal Support Plan Addendum (PSPA) from 3/21/11 described a "physical and chemical restraint." The Physician's order provided in the documentation package did not include any order for pretreatment sedation. The Incident Management Review Team (IMRT) minutes report that the Individual received pretreatment sedation (medical restraint) after returning from the morning eye appointment because the appointment had been rescheduled to the afternoon. From the available documentation it was unclear if pretreatment sedation was provided prior to the morning appointment or at all. The documentation provided to the Monitoring Team associated with this restraint was confusing and contradictory and the Monitoring Team could not reliably ascertain the sequence of events or circumstances associated with this restraint, whether the restraint episode was medical or crisis intervention, or both, and whether or not relevant policies were followed. After the review the Facility provided additional information clarifying the circumstances associated with these two restraints. Nevertheless, the documentation presented to the Monitoring Team at the time of the review was insufficient to reliably ascertain the sequence of events or circumstances associated with this restraint. In five of six (83%) of the restraint records reviewed, a review of the descriptions 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. The exception is the restraint of Individual #139 described above. The documentation provided to the Monitoring Team associated	

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		with this restraint is confusing and the Monitoring Team cannot reliably ascertain the sequence of events or circumstances associated with this restraint, whether the restraint episode was medical or crisis intervention, or both, and whether or not relevant policies were followed. For the other five restraints, documentation supports the conclusion that there was no evidence that restraints were being used for the convenience of staff or as punishment. Nevertheless, the Monitoring Team is concerned with the apparent ineffectiveness of some behavior support programs, which can lead to restraint use. Examples of ineffective program implementation, or direct support staff failure to implement programs, are provided in Sections K and S of this report. This includes examples of lack of implementation of behavior support plans and staff not recording data or not recording data accurately. In either case, this precludes the type of evidence-based treatment decisions that are essential to learning by the Individual. 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. Five of the six restraint records reviewed (83%) 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. The exception is the restraint of Individual #139 described above. The documentation provided to the Monitoring Team for restraint of Individual #139 (3/14/11) was unclear, confusing, and contradictory; the Monitoring Team could not reliably ascertain the sequence of events associated with this restraint, whether the restraint episode was medical or crisis intervention, or both, and whether or not relevant policies were followed. Additionally, the restraint checklist for this restraint did not include any entries in the "Interventions Attempted" section of the document. For the other five restraints this requirement was adequately documented on restraint checklists indicating the use of a number of pre-restraint interventions. For example, for Individual #151, interventions noted included verbal prompt, redirection, moved others away, traded out staff, and moved furniture. For Individual #122 interventions noted included prompting coping skills, verbal prompt, redirection, PMAB protection skills, and traded out staff. 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 (where provided) the documented discussion typically described what happened and what led up to the behavior that created the need for restraint but did not discuss the PBSP, its implementation, its effectiveness, and any recommended changes. Such was the	

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		case with Individual #122 who experienced multiple restraints in one day. The PST did not always meet to review the circumstances associated with restraint and therefore did not assess the clinical justification for use of restraint. The Monitoring Team did receive and review the revised SFAs and PBSPs; however, any changes recommended in these documents were not incorporated into the PSPA for review by the entire PST. Therefore, the PST would not have all the information needed to assess the clinical justification for use of restraint. Also, no documentation was provided to the Monitoring Team to establish that the PST reviewed the restraint of Individual #61. The Monitoring Team interviewed eight direct care professionals (DCPs) and asked: "from the training you've received describe some strategies you would use with an Individual whose behavior may lead to restraint?" All eight staff provided a response that indicated they were aware of the various intervention strategies taught in PMAB classes, and, reinforced in the facility specific training (including competency checks) developed by the RGSC Psychology Department. Because the use of restraint at RGSC is becoming increasingly unnecessary, it is important that staff receive ongoing competency checks to ensure that if called upon they can implement restraint in accordance with Facility policy. The SA also requires that restraint use be in "accordance with applicable, written policies, procedures, and plans governing restraint use." RGSC SOP 700-14 governs the use of restraint. The Monitoring Team reviewed two specific physician related elements of this policy to determine if policy requirements were documented in restraint records. These included: • H.2.a of the policy: "All instances of restraint as a crisis intervention require a written order, signed by a physician. This order must specify the behavior that required restraint, the kind of restraint used and time of implementation of restraint." None (0%) of the restraint records reviewed by the Monitoring Team contained physician orders with sufficient specificity to comply with this RGSC policy requirement. • H.2.d of the policy: "The physician must perform a face-to-face assessment of the patient within one hour. Face-to-face assessments must be immediately documented by the physician in the medical record and contain the following components: 1) individual's current status and review of incident, 2) justification for use of restraint, and 3) review of RN assessment." None (0%) of the restraint records reviewed by the Monitoring Team contained physician face-to-face assessments with sufficient specificity to comply with this RGSC policy requirement. Facility policies identified a list of approved restraints. Based on the review of six restraints all (100%) were restraints approved in policy.	

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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 substantial compliance with this provision of the Settlement Agreement (SA). At the time of interview, the Psychology Manager requested that the rating on the POI be changed from substantial compliance to noncompliance because a recent restraint (Individual #40 on 7/29/11) did not meet the criterion for this provision of the SA. The Monitoring Team asked for the restraint documentation for this restraint but it was not provided. Because RGSC had so few crisis restraints, one noncompliant restraint magnifies the percent of noncompliance. The Monitoring Team recognizes the efforts the Facility made to reduce use of restraints; similar efforts to ensure appropriate release and documentation thereof will help to achieve compliance. It should be clear that reducing use of restraints is a positive finding and will be taken into account when reviewing the data on percentages of compliance with various requirements of this Section. The six restraints reviewed by the Monitoring Team consisted of: • Horizontal side-lying 2 minutes (3x) • Horizontal side-lying 21 minutes • Horizontal side-lying 46 minutes • Physical hold 10 seconds The restraint release circumstances associated with these six restraints were: • Individual #61: two-minute horizontal side-lying restraint. No release code was noted on the Restraint Checklist. • Individual #62: two-minute horizontal side-lying restraint. Release code is "other-released when instructed by monitor." • Individual #122: forty-six minute horizontal side-lying restraint. Release code P – "released immediately because no longer an immediate and serious risk of harm to self/others." • Individual #122: twenty-one minute horizontal side-lying restraint. Release code P – "released immediately because no longer an immediate and serious risk of harm to self/others." • Individual #139: no release code. The documentation provided to the Monitoring Team associated with this restraint is confusing and contradictory and the Monitoring Team could not reliably ascertain the sequence of events associated with this restraint, whether the restraint episode was medical or crisis intervention, or both, and whether or not relevant policies were followed. • Individual #151: release code 0 "medical/dental procedure completed and was released." Nothing in the restraint documentation indicated a medical or dental procedure associated with this restraint. Documentation confirmed this chemical restraint was in response to a behavioral crisis. This was a chemical restraint preceded by a physical hold restraint in order to administer the chemical	Noncompliance

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		restraint. The circumstances associated with restraint release for Individuals #62, #139, and #151 suggest that additional staff training is needed. Additional documentation reviewed by the Monitoring Team, including the FFAD and PSPA documents (where provided), further validated the data presented on Restraint Checklists.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The RGSC POI reported substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team does not concur because of staff training deficiencies described below. RGSC SOP ICFMR 700-14, The Use of Restraint (4/11), guides facility practices with respect to restraint use. Review of the Facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: 1. Policies governing the use of restraint; 2. Approved verbal and redirection techniques; 3. Approved restraint techniques; and 4. Adequate supervision of any individual in restraint. RGSC SOP ICFMR 700-14, The Use of Restraint policy does not include specific classes, by reference number, required of staff. DADS restraint policy is similarly nondirective in this regard. To measure compliance with restraint related training the Monitoring Team had determined completion of the following classes are necessary to establish compliance: 1. PBS0100 Positive Behavior Support 2. PMA0320 PMAB Basic 3. PMA0400 PMAB Restraint 4. PMA0700 PMAB Prevention 5. RES0105 Restraint: Prevention and Rules for Use at MR Facilities All classes are to be taken pre-service and every 12 months thereafter. The Monitoring Team chose a sample of 25 employees for review of training transcripts. This will be referred to as Sample C-2 throughout the report. Staff training transcripts for these 25 employees were reviewed with the following results: • PBS0100 Positive Behavior Support: 20 of 25 (80%) had completed this training within the last 12 months.	Noncompliance

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		• PMA0320 PMAB Basic: all 25 (100%) had completed this training within the last 12 months. • PMA0400 PMAB Restraint: all 25 (100%) had completed this training within the last 12 months. • PMA0700 PMAB Prevention: all 25 (100%) had completed this training within the last 12 months. • RES0105 Restraint: Prevention and Rules for Use at MR Facilities: 22 of 25 (88%) had completed this training within the last 12 months. In addition to this required training the RGSC had created facility specific competency-based restraint training for 1) PST members, 2) direct care professionals, 3) nursing staff, and, 4) staff serving as restraint monitors. This training, and the accompanying competency checks, provided very useful facility specific training to supplement the required training classes. Eight direct care professionals were interviewed to determine whether they had a fundamental understanding of restraint policy and procedures. All eight (100%) demonstrated sufficient knowledge. Six of the eight DCP's interviewed had been directly involved in using restraints. Interviews included staff from two shifts. The Monitoring Team would generally expect all employees would receive required training for each required training class, except when there are extenuating circumstances, to be considered in substantial compliance with that element of this provision of the SA. As noted in Section C.1 five of six (83%) 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. The one that did not contained confusing information such that the Monitoring Team was unable to make a determination of compliance/noncompliance.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical	The RGSC POI reported lack of compliance with this provision of the Settlement Agreement (SA). This was due to the lack of PST review and supports prior to 76% of medical restraints. The Monitoring Team concurs with this self-assessment. From a review of six crisis intervention restraint records (Sample C.1), five (83%) included evidence documenting that restraint was used as a crisis intervention. The exception was the restraint of Individual #139 described earlier in this report, for which additional information was provided following the visit.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Documentation provided by the Facility for the six crisis intervention 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. The Facility was not using (or did not provide) the DADS form that is used for this purpose at other facilities: "Considerations for Implementing Restraint Medical/Physical." At the last compliance review the Monitoring Team noted that the Facility had initiated improvements that had significantly decreased the need for pretreatment sedation (medical restraint). Several new medical/dental providers had established relationships with the RGSC. These providers were more willing to work with RGSC individuals without pretreatment sedation. RGSC was using a portable dental operatory 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 also initiated a process for the development of individualized support plans for individuals going to medical appointments who in the past required pretreatment sedation. These plans identified 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 Monitoring Team was able to confirm that all these practices remained in place. As reported in Provision J.4, however, there are still examples in which formal programs to minimize the need for pre-treatment sedation and restraint are lacking. The frequency of use of pre-treatment sedation remained low. The average number of medical restraints per month had increased slightly, from eight per month in the six months preceding the last review, to nine per month since the last review. Most pre-treatment sedation (84%) was for medical procedures. Pre-treatment sedation for dental procedures accounted for only 16% of medical restraint. This validates the success the Facility has had in supporting individuals in the provision of dental care. Since most medical restraint is in the area of medical procedures the Facility's PSTs may need to develop more aggressive strategies in preparing Individuals for medical procedures, which typically occur away from the Facility. The Monitoring Team sampled medical restraint documentation for nine instances of medical restraint that occurred since the last review. All nine were pre-treatment sedation. In only one (11%) did the documentation provided by the Facility include a Specific Program Objective (SPO), or other documentation, that described a formal effort	

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		to reduce the need to use pretreatment sedation with those individuals. This further supports the view of the Monitoring Team that PSTs need to be more aggressive in developing strategies to minimize use of pre-treatment sedation for those individuals still needing these supports.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	The RGSC POI reported lack of compliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs. Review of Facility training documentation showed that there were adequate training curricula on the application and assessment of restraint. The training developed for Restraint Monitors by the Psychology Manager was competency based and included several training tools developed specifically for use at RGSC. Restraint documentation completed by restraint monitors (FFADs) 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. The one significant exception to this was the restraint of Individual #139 described earlier in this report. The Facility provided the Monitoring Team with a list of 26 staff designated as Restraint Monitors. Five (20%) were selected for review of training requirements. RGSC restraint policy requires that restraint monitors complete the following training: 1. PBS0100 Positive Behavior Support 2. PMA0320 PMAB Basic 3. PMA0400 PMAB Restraint 4. PMA0700 PMAB Prevention 5. RES0105 Restraint: Prevention and Rules for Use at MR Facilities 6. CPR0100 Basic 7. RIG0100 Rights of Consumers 8. ABU0100 Abuse and Neglect All classes are to be taken pre-service and every 12 months thereafter. In addition, Restraint Monitors are to successfully complete training conducted by the Psychology Manager on conducting and documenting the face-to-face assessment and debriefing. This training includes a Restraint Monitor Competency Check which all five restraint monitors in the sample successfully completed. All five restraint monitors had completed all required training. There were several instances were training had not occurred within the prescribed 12 month interval. Two of the five (40%) were not current with RES0105 and one (20%) was not current with CPR0100.	Noncompliance

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		The restraint monitors who had not completed all required training timely did not monitor any of the crisis intervention restraints in Sample C.1. All six restraint documentation files contained an FFAD. With the exception of the restraint of Individual #139 they were completed correctly, were descriptive, and included entries indicating the document had been reviewed by the Unit Administrator. In five instances (83%), the documentation on the FFAD showed that an assessment was completed of the application of the restraint. In zero instances (0%), the documentation on the FFAD showed that an assessment was completed of the circumstances of the restraint. There were brief entries in section 3 of the FFAD. These entries 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 may be contained in the PSPA and IMRT meetings that review the restraint episode but evidence of this was not presented to the Monitoring Team.. None of the six crisis intervention restraint records in the sample indicated an alternative physician-ordered monitoring schedule. Based on a review of six restraint records for restraints that occurred at the Facility (Sample #C.1), there was documentation that a licensed health care professional: ▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in two (33%) of the instance of restraint. Listed below are individuals and dates of each restraint record where this did not occur: o Individual #139: 3/14/11 at 1:30 p.m. o Individual #15: 6/14/11 at 2:19 p.m. o Individual #122: 6/24/11 at 11:13 p.m. and 6/24/11 at 6:37 p.m. ▪ Monitored and documented vital signs in four (67%). Records that did not contain documentation of this included: Individuals and dates of each restraint record where this did not occur: o Individual #139: 3/14/11 at 1:30 p.m. o Individual #122: 6/24/11 at 11:13 p.m. ▪ Monitored and documented mental status in four (67%). Records that did not contain documentation of this included: Individuals and dates of each restraint record where this did not occur: o Individual #139: 3/14/11 at 1:30 p.m. o Individual #122: 6/24/11 at 11:13 p.m. Sample C.3 was selected from the list of individuals who had medical restraint since the last review. It represents 20% of the medical restraints used since the last review. It	

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		included the following eight individuals and nine restraint episodes: Individuals #3 (7/5/11), #31 (7/8/11), #36 (4/8/11 and 5/16/11), #62 (7/11/11), #91 (5/25/11), #93 (6/14/11), #108 (6/8/11), and #145 (4/8/11). For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring from the materials provided subsequent to the document request. In none of the nine (100%) medical restraints reviewed did the physician specify the schedule and type of monitoring required. Three included a notation "sedation due process" but it was unclear to the Monitoring Team what this language was intended to convey to staff and no explanation was provided. None of the nine (100%) medical restraints in the sample indicated an alternative monitoring schedule or type ordered by the physician. All nine incidents of medical restraint were chemical restraint. One restraint (Individual #3) did not include the physician order for the chemical restraint.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	The RGSC POI reported lack of compliance with this provision of the Settlement Agreement (SA). This was because RGSC internal monitoring identified the level of supervision for individuals receiving chemical restraint for pre-treatment sedation was not being specified. The Monitoring Team concurs with this self- assessment. A sample (Sample C.1) of six Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: • In four (67%), continuous one-to-one supervision was documented. • In five (83%), the date and time restraint was begun was documented. • In five (83%), the location of the restraint was documented. • In five (83%), information about what happened before, including the change in the behavior that led to the use of restraint was adequately documented. • In four (67%), the interventions taken by staff prior to the use of restraint were adequately documented and are adequate for post restraint review. • In five (83%), the specific reasons for the use of the restraint were adequately documented. • The Monitoring Team found that when taken together the information provided on the restraint checklist, the FFAD, and the debriefing the specific reason for the use of restraint was apparent in five (83%) of six cases. • In five (83%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated on the restraint checklist. • In five (83%), the names of staff involved in the restraint episode were indicated on the restraint checklist. The Restraint Checklist documented observations of the individual and actions taken by	Noncompliance

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		staff while the individual was in restraint, including: • In five (83%), the observations were documented at least every 15 minutes and at release. • In five (83%), the specific behaviors of the individual that required continuing restraint were noted. • Because of the short duration of 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. • In two (33%), the level of supervision provided during the restraint episode was not recorded on the restraint checklist. • In five (83%), the date and time the individual was released from restraint was recorded on the restraint checklist. • In four (67%), 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 #122 (6/24/11) there was no indication of a post restraint nursing assessment. For Individual #139 restraint documentation was confusing and contradictory. • In the sample of six records (Sample C.1), restraint debriefing forms had been completed for four (67%). Restraint documentation for Individual #11 did not include the debriefing form. For Individual #139 restraint documentation was confusing and contradictory. Crisis intervention chemical restraint of Individual #122 (6/24/11) and Individual #151 were included in Sample C.1. The documentation for the restraint of Individual #122 included an "Administration of Chemical Result Consult" but did not include the required "Chemical Restraint Clinical Review" which is part of the FFAD process. The documentation for the restraint of Individual #151 did not include the required "Administration of Chemical Result Consult" but did include the "Chemical Restraint Clinical Review" which is part of the FFAD process.	
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. 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 more than three times in any rolling thirty day period.	Not Rated

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	(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
	(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	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	Not Rated

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	with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	requirements of this element of this provision.	
	(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. The Monitoring Team does not concur. The RGSC process for reviewing each episode of restraint, as reported by staff and confirmed through observation and document review, began with a FFAD done by the restraint monitor immediately after the restraint episode. The restraint episode was reviewed in the unit morning meeting the next business day with whatever information has been prepared by the time of the meeting. This often consisted of verbal reports from staff. It was 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 was kept on the agenda of both meetings until the restraint checklist, FFAD, 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 were put in place and tracked by the Incident Management Coordinator using a descriptive computer data base until closed. Documentation of these reviews was contained in IMRT meeting minutes and usually contained sufficient information to facilitate an adequate review of the circumstances under which restraint was used. There is also space on the FFAD 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 to be documented in a Personal Support Plan Addendum (PSPA) that becomes part of the permanent record. A sample of documentation related to six 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. The IMRT review of the restraint of Individual #139 seems to have sorted out the confusion and	Substantial Compliance

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		contradictory documentation presented to the Monitoring Team in the document request. This IMRT review should have also identified the need for preparation of a supplemental Restraint Checklist and FFAD so that restraint documentation would accurately reflect the circumstances associated with the restraint episode.	

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

1. The Facility should engage in rigorous review of restraint documentation to ensure all required policies and procedures are followed and properly documented (C.1, C.2, C.3, C.4, C.5, C.6, and C.8).
2. The Facility should develop more aggressive strategies in preparing Individuals for medical appointments (C.4).
3. The Facility should more closely monitor the completion dates of required training (C.3).

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement (POI) 8/9/11 2. RGSC SOP ICFMR 200-08 Protection from Harm – Abuse, Neglect, and Exploitation (revision date 6/11) 3. RGSC SOP ICFMR 200-03 Incident Management (revision date 6/11) 4. RGSC SOP ICFMR 400-01 Injuries to Consumers (revision date 5/11) 5. DADS Policy 2.1 Protection From Harm - Abuse, Neglect, and Exploitation (6/18/10) 6. DADS Policy 2.2 Incident Management (1/31/11) 7. Poster used to inform staff, individuals, LARs, and visitors of A/N reporting responsibilities and related monitoring report (7/22/11) 8. Criminal Background Check Due Diligence Report from DADS (8/24/11) 9. Personal Support Plan (PSP) and Positive Behavior Support Plan (PBSP) for Individuals #15, #61, #122, and #139 10. Training transcripts of Facility and DFPS investigators 11. DFPS Investigator Training Outlines and Competency Tests (undated) 12. Acknowledgement of Responsibility for Reporting Abuse, Neglect, and Exploitation forms for sample of 25 employees 13. RGSC Unusual Incident Investigation Review Checklist (11/24/10) 14. Incident Management Tracking Log (7/11) 15. List of Peer caused injuries 3/1/11 to 7/31/11 16. Witnessed Injury Log 3/1/11 to 6/30/11 17. Discovered Injury Log 3/1/11 to 6/30/11 18. Unusual Incident Log 3/1/11 to 7/20/11 19. Department of Family and Protective Services Investigative Reports and related documents 38698414, 38700988, 38714129, 38866156, 39657647, 40070568, 40118787, 40133929, 40205828, 40209120, 39575848, 39633847, 38689838, and 40241495 20. State Supported Living Center OIG Case Report Document Checklist (8/31/09) 21. Facility investigations for discovered injuries for Individuals #60 (4/28/11), #61(4/6/11 and 6/12/11), #80 (5/13/11 and 8/18/11), and #91 (6/2/11) 22. Facility investigations for serious injuries and incidents UIRs 11-018, 019, 020, 021, 022, 023, 024, and 025 23. Customer Satisfaction Survey Family Members of Persons Served at the State Center (9/10) 24. Material used to educate guardians on abuse reporting (3/11) 25. Sample documentation of employee discipline taken post investigation 26. Incident Management Review (IMRT) minutes for 15 meetings from 3/1/11 to 8/22/11 27. Self-Advocates meeting minutes 3/1/11, 4/13/11, 5/24/11, 6/14/11, 7/12/11, and 8/23/11 28. Under Reporting Record Review 6/8/11 and 7/15/11

	29. UIR Audits 4/5/11(2x), 5/25/11(2x), 6/15/11 (2x), 7/11/11 and 8/12/11(2x) 30. Completed SA Section D Monitoring Tools 2/7/11, 4/21/11, and 5/11/11 31. FY11 Allegations Trend Report 32. List of current staff (8/22/11) 33. Training Transcripts for sample of 25 staff **People Interviewed:** 1. Sonia Hernandez-Keeble, Superintendent 2. Blas Ortiz, Jr., Assistant Superintendent 3. Myrna Wolfe, Incident Management Coordinator 4. Lorraine Hinrichs, ICF-MR Program Director 5. Mary Ramos, Quality Management Director 6. Rosie Sanchez, QE Coordinator 7. Alondra Machado, Data Analyst 8. Janie Villa, QMRP Manager 9. Juanita Newton, DFPS Investigator 10. Sidney Lyle, OIG Sergeant Investigator **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 8/22/11 2. Settlement Agreement Performance Improvement Council (SA-PIC) 8/24/11 3. Self-Advocate Meeting 8/23/11
	Facility Self-Assessment: The RGSC POI reported that it was in substantial compliance with three of the five (60%) provisions in section D. These were D.1, D.3, and D.5. These provisions included policy commitments to zero tolerance of abuse, the incident/investigation review requirements and process, and background checks of employees and volunteers. The Monitoring Team determined that the RGSC was in substantial compliance with one provision, D.5 which addresses background checks of employees and volunteers. The Facility did not have a specific methodology to conduct a self-assessment of compliance with the provisions of this section of the SA. Provisions D.2 includes nine components, all of which must be in substantial compliance in order for the provision to be in substantial compliance. The RGSC POI reported substantial compliance with six of the nine components. The Monitoring Team determined that the RGSC was in substantial compliance with six of the nine components. Provisions D.3 includes ten components, all of which must be in substantial compliance in order for the provision to be in substantial compliance. The RGSC POI reported substantial compliance with all ten of the components. The Monitoring Team determined that the RGSC was in substantial compliance with nine of the ten components. Most activity undertaken by the RGSC to determine self-assessment ratings was anecdotal information and administrative perception of progress. The RGSC should develop more formalized procedures, where applicable, to measure progress in determining self-assessment ratings.

	Summary of Monitor's Assessment: The systems for abuse/neglect reporting and the incident management system at RGSC have improved since the last compliance review. Facility policies had been reviewed and revised to include SA requirements previously missing. The information presented in the Facility Self-Assessment indicates the Facility is close to achieving substantial compliance with this provision of the SA. There are still several areas where significant improvement is needed. This includes the timely reporting of incidents and the timely commencement of investigations. The internal management and monitoring systems in place at RGSC are self-identifying most instances of noncompliance but additional work is needed to reduce frequency. Late reporting suggests staff knowledge needs to improve. The Facility had established a system of competency checks that focus on reporting to DFPS. The Facility may need to expand these competency checks to ensure staff have more in-depth knowledge of activities and events that represent reportable incidents. The IMRT process appears to be functioning well. Improvements from the last compliance report were evident. 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 recorded on trend reports continues to need improvement, most notably in the separate categorization of incidents investigated by DFPS. 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. The Monitoring Team does not concur. 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. RGSC SOP ICFMR 200-08 Protection from Harm – Abuse, Neglect, and Exploitation (revision date 6/11), requires staff 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. This policy, along with RGSC SOP ICFMR 200-03 Incident Management (revision date 6/11) and RGSC SOP ICFMR 400-01 Injuries to Consumers (revision date 5/11) provide the policy direction, if followed, needed to achieve compliance with this	Substantial Compliance

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		section of the SA. The Monitoring Team reviewed 13 investigation reports, a 20% sample. Six (46%) included evidence that serious incidents, including allegations of abuse, neglect, and/or exploitation, were not reported within the timeframes required by DADS and Facility policy and the SA. Timely reporting is an essential and important component to properly implement policies, procedures and practices in support of the Facility's commitment to not tolerate abuse or neglect of individuals. This is an example of the importance of not only developing a policy but of ensuring it is fully implemented. Although the required policy is in place, it will be essential for the Facility to demonstrate continuing improvement in implementation.	
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 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 in compliance for the provision to be considered in substantial compliance	
	(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 compliance with this component of this provision of the SA. The Monitoring Team does not concur. In the last compliance review the Monitoring Team noted that RGSC SOP ICFMR 200-07 did not provide instruction specific to the reporting of serious incidents and the Monitoring Team was not provided any other policy that included such instructions. This policy had been revised to include the reporting of serious injuries but needs further revisions to include the reporting of other types of serious incidents. The following represents the numbers of allegations that occurred at the Facility for the six-month period from 2/1/11 through 7/31/11. Total abuse allegations – 47 The disposition of these 47 cases included 3 substantiated, 8 determined inconclusive, 27 unconfirmed, 7 unfounded, 1 referred back to the Facility as an administrative matter, and 1 merged with other cases. Total neglect allegations – 16	Noncompliance

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		The disposition of these 16 cases included, 3 substantiated, 2 determined inconclusive, 9 unconfirmed, and 2 referred back to the Facility as an administrative matter. Total exploitation allegations – 0 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 and follow-up by the Facility. Based on an interview of eight staff responsible for the provision of supports to individuals, eight (100%) were able to correctly describe the reporting procedures for abuse, neglect, and/or exploitation. Two reported they would first call Facility administration and then call DFPS but they were clear they were to call DFPS, not wait to be instructed as to whether to call DFPS or not. The Facility had implemented an audit process in February, 2011. The Human Rights Officer interviewed 10 staff each month asking them standard questions on abuse/neglect/exploitation policy and reporting. Responses were recorded and documented in a report submitted to the QA Director. Any staff who responded to any question incorrectly was provided on the spot retraining. A training roster was maintained to document this training occurred. RGSC's Unusual Incident Log provided data on serious injuries. From this report the Monitoring Team was able to determine the RGSC had three serious injuries between 2/1/11 and 7/22/11. Review of the investigation of these three serious injuries will comprise sample D.2. Two samples of investigations were selected for review. These included: • Sample D.1 included a sample of ten (20%) DFPS investigations of abuse, neglect, and/or exploitation between 3/1/11 and preparation of the previsit document request.. This sample included the following DFPS investigation reports: 38698414, 38700988, 38714129, 38866156, 39657647, 40070568, 40118787, 40133929, 40205828, and 40209120. Cases were selected to ensure both abuse and neglect allegations were included, and to ensure case dispositions of confirmed, unconfirmed, and inconclusive were represented in the sample. • Sample D.2 included the three Facility investigations of serious injuries between 3/1/11 and 8/22/11. This included the following investigations: UIRs 11-021, 11-024, and 11-025. Based on a review of the 13 investigation reports included in both Sample D.1 and	

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		Sample D.2, seven (54%) 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: 1. DFPS 38698414: The DFPS report stated the date and time of the incident was 3/3/11 at 3:00pm and it was reported to DFPS on 3/3/11 at 4:32pm. 2. DFPS 38700988: The DFPS report stated the date and time of the incident was 3/4/11 at 8:10am and it was reported to DFPS on 3/4/11 at 11:39am. 3. DFPS 38714129: The DFPS report stated the date and time of the incident was 3/7/11 at 6:48pm and it was reported to DFPS on 3/7/11 at 8:41pm. 4. DFPS 40205828: The DFPS report stated the date and time of the incident was 7/16/11 at 7:30pm and it was reported to DFPS on 7/18/11 at 11:08am. 5. DFPS 40209120: The DFPS report stated the date and time of the incident was 7/18/11 at 11:20pm and it was reported to DFPS on 7/20/11 at 3:54pm. 6. RGSC UIR 11-021: The UIR indicates this incident occurred on 5/4/11 and was not reported until 6/13/11. The Facility had a standardized reporting format that meets generally accepted standards with sufficient information necessary for adequate follow-up, as well as tracking and trending of incidents. Based on a review of 13 investigation reports included in Sample D.1 and Sample D.2, 13 (100%) contained a copy of the report utilizing the required standardized format. An additional element of properly reporting allegations of abuse and neglect is the investigation of discovered injuries. These investigations are conducted to determine, among other things, whether abuse and neglect can be ruled out as the cause, or a contributing factor, of the injury. The Monitoring Team reviewed six investigations and identified several issues: 1. Staff interviews and statements usually focus on the staff on duty at the time the injury was discovered. Many discovered injuries are discovered at the start of a shift and are bruises which suggest the cause of the injury occurred prior to the start of the shift. Staff interviews and statements should also include staff on duty during at least the prior shift. 2. Many individuals at RGSC receive 1:1 Level of Supervision (LOS). LOS status is not recorded on the preliminary or secondary investigation documents. This is important information. If an Individual has 1:1 LOS one would expect staff to be more knowledgeable of what may have caused the injury, or that the injury may	

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		have occurred as a result of staff neglect. 3. Certain discovered injuries, even though not rated serious, may warrant a more extensive investigation than is typical, including review of video surveillance tapes. This might be the case for an Individual who is frequently injured, or where the location of the injury might automatically raise suspicion with respect to inappropriate interaction with staff, or peer-to-peer interaction. 4. The investigation (preliminary and secondary investigation documents) of certain discovered injuries, even though not rated serious, may warrant review by a Facility investigator or the IMC. For example: a. Individual #80 is on I:1 LOS and incurred a discovered injury on 5/13/11 described as a "bruise to rib cage" and another discovered injury on 8/18/11 described as a "reddish bruise to right thigh." The 5/13/11 injury was attributed to staff use of a gait belt in assisting the individual to the floor. There was no evidence that indicated any follow-up discussion or actions to address or consider the possibility of a safer procedure. There is also the issue of how a person with 1:1 LOS experiences discovered injuries. b. Individual #60 had a discovered injury on 4/6/11 described as a bruise to the wrist. This person told the staff conducting the investigation how she injured her wrist and her account was accepted. The Individual had another discovered injury on 6/12/11 described as a bruise to the right abdomen. This person told the staff conducting the investigation how she injured her abdomen and this time her account was not accepted. It would seem that she would either be considered a reliable reporter or not. This suggests a lack of thoroughness in the review of discovered injuries to rule out abuse or neglect.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the	The RGSC POI reported substantial compliance with this component of this provision of the SA. The Monitoring Team concurs. Facility policy (ICFMR 200-08) was revised in June, 2011. Revisions included the addition of language that required the removal of alleged perpetrators from contact with individuals. Review of 13 investigation reports included in Sample D.1 and Sample D.2, showed that in every instance where an alleged perpetrator (AP) was known the AP was immediately placed in no direct contact status. Review of the 10 investigations of abuse or neglect in Sample D.1 found there were not any instances in which a staff person who had been removed from direct contact was subsequently returned to normal duties until the investigation had been completed and	Substantial Compliance

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	employee poses no risk to individuals or the integrity of the investigation.	the investigation review process determined it was appropriate for the staff person to return to his/her normal assignment. Based on a review of the 13 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 was done, 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. The Facility self-assessment reported that staff competency checks do not always indicate 100% compliance. In reviewing competency checks completed since the last monitoring review the Monitoring Team calculated a compliance rate of 92%. These data, and the on-the-spot retraining that accompanies the competency checks, is sufficient to demonstrate substantial compliance. The Monitoring Team has determined this component of this provision to be in substantial compliance. 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 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. A review of the training curricula related to abuse and neglect was carried out for: a) new employee orientation; and b) annual refresher training. The results of this review were as follows: In relation to the requirement that training is competency-based, the material reviewed 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. Review of 25 staff records (Sample C.2), showed that 25 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the previous 12 months. Twenty-five (100%) had completed competency-based training on unusual incidents (UNU0100) within the previous 12 months. Based on interviews with 10 staff: 5. Ten (100%) were able to list signs and symptoms of abuse, neglect, and/or	Substantial Compliance

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		exploitation with sufficient depth to demonstrate competency of understanding; and 6. Ten (100%) was able to describe the complete reporting procedures for abuse, neglect, and/or exploitation. Additionally, the Facility had implemented an audit process in February, 2011. The Human Rights Officer interviewed 10 staff each month asking them standard questions on abuse/neglect/exploitation policy and reporting. Responses were recorded and documented in a report submitted to the QA Director. Any staff who responded to any question incorrectly was provided on the spot retraining. A training roster was maintained to document this training occurred.	
	(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. Facility policy (ICFMR 200-08) was revised in June, 2011. Revisions included the addition of language that required staff persons who are mandatory reporters of abuse or neglect to sign a statement kept at the Facility evidencing their recognition of their reporting obligations. This is documented on a DADS form 1020. Copies were requested of the forms for the eight staff hired during the two full months prior to the on-site review. All staff hired in the two months had completed the required acknowledgment form. Form 1020 was requested for the 25 employees in Sample C.2. Properly signed forms for all 25 staff were provided to the Monitoring Team. The Facility did not identify any incidents of failure to report. The Monitoring Team, in its review, also did not identify any incidents of failure to report. The Monitoring Team identified several instances of reporting that did not meet the timeliness requirements called for in the SA. One such incident (UIR 11-021) occurred on 5/4/11 and was not reported until 6/13/11. This was a serious injury that was not reported until staff in QA detected the issue. Detection by QA and subsequent reporting indicates the Facility had a process in place that could identify issues that should have been reported and that the Facility took action upon detection.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide	The RGSC POI reported lack of compliance with this component of this provision of the SA and the Monitoring Team concurs. Facility policy (ICFMR 200-08) was revised in June, 2011. Revisions included the addition of language that required maintaining a resource guide on recognizing and reporting signs of abuse, neglect, and exploitation of individuals and providing it to the individuals, their primary correspondent, and their LAR. This revision also required that this	Noncompliance

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	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.	resource guide be provided to individuals at admission to the Facility and annually to coincide with PSP preparation and at the PSP meeting. Evidence was provided to the Monitoring Team which validated that RGSC provides guardians and LARs with written material directed at identifying and report unusual incidents, including allegations of abuse, neglect and exploitation. These materials are provided to LARs prior to each individuals PSP meeting and are available in both English and Spanish. This is especially important at the RGSC since Spanish is the preferred language of many Individuals and their family. The PST is required to meet with each individual prior to their PSP meeting to review this information as well. The PST is required to review this information at the PSP meeting with the individual and his/her guardian or LRA. The Facility had recently modified the PSP Observation Monitoring Tool to record whether or not the PSP meeting covered these topics. This was done in early August, 2011. Monitoring Team members attended the one PSP meeting held the week of the review and there was discussion of abuse, neglect or other reportable incidents. The Monitoring Team reviewed the PSPs for Individuals #15, #61, #122, and #139 and there was no evidence to suggest discussion of this topic. The PSP revised monitoring tool was not yet fully in use so no data were available to determine the degree to which these educational expectations had occurred. In conversation with Individuals attending the self-advocate meeting on 8/23/11 it was apparent to the Monitoring Team that at least those in attendance understood what they would do if someone hurt them, or they had a problem with which they needed help. No serious incidents had been identified as being reported by an individual, their LAR, or others who were significantly involved in their lives, although it was reported that a guardian reported an incident to a staff person who subsequently reported it to DFPS. The Monitoring Team believes the RGSC can achieve substantial compliance with this component once consistent application of the practices observed during the review is evident.	
	(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 concurs. Observations made by the Monitoring Team confirmed the presence of the required posters in multiple locations in each residential and work area, and other buildings frequented by Individuals. Most posters were mounted in attractive framed cases. Others were laminated for durability. In all locations posters were displayed in both English and	Substantial Compliance

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		Spanish. This is especially important at the RGSC since Spanish is the preferred language of many Individuals and their family.	
	(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 concurs. RGSC SOP ICFMR 200-08 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 6/11) and RGSC SOP ICFMR 200-03 Incident Management (revision date 6/11) included specific requirements associated with this component of the SA. Based on a review of 10 allegation investigations completed by DFPS (Sample D.1) DFPS had made law enforcement referrals in seven (70%) cases. The three cases that did not include law enforcement referrals included two allegations of neglect and one allegation of verbal abuse. None of these three allegations resulted in injury to the Individual. The Monitoring Team is not of the opinion these three cases merited specific law enforcement referral. All allegations of physical abuse were referred to law enforcement. Based on a review of three investigations completed by the Facility (Sample D.2), one facility investigation concluded the injury should be reported to DFPS and the Office of Inspector General OIG (i.e. law enforcement). For the other two Facility investigations 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.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The RGSC POI reported substantial compliance with this component of this provision of the SA. The monitor team concurs. RGSC SOP ICFMR 200-08 titled Protection from Harm – Abuse, Neglect, and Exploitation (revision date 6/11) included specific requirements in section IX associated with this component of the SA. 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. In conversation with Individuals attending the self-advocate meeting on 8/23/11 it was apparent to the Monitoring Team that at least those in attendance understood that if they had a problem with which they needed help (e.g. retaliation) they would know who to talk to. All eight direct support professionals interviewed by the Monitoring Team did not	Substantial Compliance

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		express any fear of retaliation and reported administration would take appropriate action should it occur. Based on a review of investigation records (Sample D.1 and Sample D.2), there were no concerns noted related to potential retaliation. The Facility was asked for a list of staff since the last review against whom disciplinary 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. RGSC initiated a process in December, 2010 of reviewing two records a month to detect whether the record reflects any injuries that occurred and weren't reported. The data collection form used by the Health Information Management department was revised since the last compliance review and now calls for the reviewer to look at the last 90 days of injury reports, progress notes, care flow sheets and the nursing quarterly report and biophysical assessment. Previous to this change the look back period was only 30 days. It was reported that two audits are to be completed each month: however, only audits for June, July, and August were provided to the Monitoring Team. One of the audits for August (Individual #86) identified two injuries for which an Injury Report could not be located. There was not any information recorded on the Under Reporting Record Review document to indicate how this issue was going to be resolved and who would be responsible (i.e. a Corrective Action Plan). To achieve substantial compliance with this component of this provision the Monitoring Team would expect to see audits done consistently and evidence that issues identified in an audit are corrected.	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		

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	policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The RGSC POI reported substantial compliance with this component of this provision of the SA and the Monitoring Team concurs. The Monitoring Team review of RGSC Policy 200-03 and 200-08 found they described in a comprehensive fashion the conduct of investigations; required that investigators be qualified and identified 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. The Monitoring Team review of RGSC Policy 400-01 Injuries to Consumers described a review process for discovered injuries in that was intended to rule out abuse or neglect as a cause, or contributing factor, to the injury. The Monitoring Team reviewed material used by DFPS in training its investigators. The required class "MH&MR Investigations ILSD" consists of the following modules: 1. Introduction and History of DFPS, APS, DADS, and DSHS 2. Laws, Rules, & Policies Governing APS MH&MR Investigations 3. Dynamics of Abuse, Neglect, and Exploitation 4. Psychiatric Terms 5. Client Rights 6. Prevention and Management of Aggressive Behavior 7. Evidence Collection 8. Basic Interviewing 9. Interviewing Persons with Developmental Disabilities 10. MH&MR IMPACT Technical Guide 11. Analysis of Evidence 12. Effective Writing 13. Disposition of Cases The required class MH&MR Investigations ILASD includes the following modules: 1. Cross-Cultural Interviewing 2. Strengthening the Written Report 3. Deception and Confrontation of Deception 4. Time and Stress Management In reviewing the materials associated with these modules, and in consideration that DFPS case investigations reviewed by the Monitoring Team were generally thorough and comprehensive and case reports were generally well written, the Monitoring Team is of	Substantial Compliance

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		the opinion that this training is competency-based and is achieving the desired results. RGSC policy required that Facility Investigator training is to consist of the following classes: 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. 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 (APS Facility BSD 1 & 2 are considered equivalent to ILSD and ILASD). 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. DFPS had five investigators assigned to work RGSC cases. The training records for these investigators were reviewed. All five (100%) completed the requirements for investigations training. Three investigators also completed the MH/MR overview. DFPS investigations reviewed by the Monitoring Team were conducted by these five investigators. RGSC had three staff designated as principal investigators, which includes the Incident Management Coordinator. The Monitoring Team reviewed their training records. All three (100%) had completed all required classes. 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. All three (100%) had completed all required classes. None of the staff designated as investigators had supervisory responsibilities (other than the IMC who supervised two investigators) and therefore were not in the direct line of supervision of anyone subject to investigation.	
	(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 concurs. 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,	Substantial Compliance

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		which consisted of DFPS investigations and Facility investigations, respectively. Review of the investigation files in Sample D.1 and Sample D.2 showed that in all 13 (100%) investigations, Facility staff cooperated with DFPS and RGSC investigators. In addition, the Monitoring Team interviewed a DFPS Investigator and an OIG Investigator. Both expressed a high level of cooperation between Facility administrative staff and themselves. Neither reported any unusual issues with cooperation from alleged perpetrators and collateral witnesses.	
	(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. 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 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." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ Ten of 10 (100%) investigation records from DFPS (Sample D.1) identified no evidence of interference by one agency or the other in any of these 10 case files. ▪ Of the three investigation records from the Facility (Sample D.2), one had been referred to law enforcement. This was a serious injury with suspicion of abuse or neglect. There was no evidence in this case report of any interference by one agency or the other.	Substantial Compliance
	(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. 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. Additionally, when interviewed by the Monitoring Team neither the DFPS Investigator or the OIG Investigator reported any issues with evidence protection.	Substantial Compliance

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	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	The RGSC POI reported substantial compliance with this component of this provision of the SA. The Monitoring Team does not concur. In the previous compliance report the Monitoring Team addressed a number of SA requirements that were not addressed in the RGSC Incident Management policy. The policy was revised in June 2011 and these policy omissions were addressed. 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. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: Five of the 10 (50%) commenced within 24 hours or sooner, if necessary, of the incident being reported. 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: • Investigation 38700988 was an allegation of physical abuse reported to DFPS on 3/4/11 at 11:39am. The initial face-to-face interview occurred at 2:55pm the same day; however, the interview was with the alleged victim who was not verbal. Staff interviews did not begin until 3/7/11. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. • Investigation 39657647 was an allegation of neglect reported to DFPS on 6/3/11 at 10:27am. The initial face-to-face interview occurred at 3:50pm the same day; however, the interview was with the alleged victim who "did not answer any questions related to the report." Staff interviews did not begin until 6/8/11. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. • Investigation 40070568 was an allegation of physical abuse reported to DFPS on 7/6/11 at 4:17pm. The initial face-to-face with the alleged victim was on 7/8/11. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided.	Noncompliance

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		• Investigation 40205828 was an allegation of physical abuse reported to DFPS on 7/18/11 at 12:23pm. The initial face-to-face interview occurred at 3:20pm the same day; however, the interview was with the alleged victim who was nonverbal. Staff interviews did not begin until 7/26/11. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. • Investigation 40209120 was an allegation of physical abuse reported to DFPS on 7/20/11 at 3:54pm. The initial face-to-face interview occurred at 3:55pm on 7/21/11; however, the interview was with the alleged victim who was nonverbal. Staff interviews did not begin until 7/25. No additional documentation of other substantive investigatory activities occurring within 24 hours of the report was provided. A new DFPS commencement policy was implemented on 8/1/11 that requires additional documentation of the substantive investigatory work conducted in the first 24 hours. This might provide documentation that will enable a finding of compliance if, in fact, the work reported is substantive. All 10 (100%) investigations were completed within 10 calendar days of the incident. All 10 (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. In four of the investigations reviewed, recommendations for corrective action were included. In all four the recommendations were appropriate and adequate to address the findings of the investigation. <u>Facility Investigations</u> The following summarizes the results of the review of three Facility investigations: Documentation contained in the UIR shows that all three investigations (100%) commenced within 24 hours or sooner, if necessary, of the incident being reported. Documentation contained in the UIR shows that all three investigations (100%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. All three (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.	

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		In all three of the investigations reviewed, recommendations for corrective action are included. In all three of the investigations (100%), the recommendations appeared adequate to address the findings of the investigation.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	The RGSC POI reported substantial compliance with this component of this provision of the SA. The Monitoring Team concurs. RGSC SOP ICFMR 200-03 titled Incident Management (revision date 6/11) included specific requirements associated with this component of the SA. 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: ▪ Each serious incident or allegations of wrongdoing; ▪ The name(s) of all witnesses; ▪ The name(s) of all alleged victims and perpetrators; ▪ The names of all persons interviewed during the investigation; ▪ For each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; ▪ All documents reviewed during the investigation; ▪ All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; ▪ The investigator's findings; and ▪ The investigator's reasons for his/her conclusions. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In all 10 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. ▪ The report utilized a standardized format that set forth explicitly and separately o In 10 (100%), each serious incident or allegations of wrongdoing; o In 10 (100%), the name(s) of all witnesses;	Substantial Compliance

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		o In 10 (100%), the name(s) of all alleged victims and perpetrators; o In 10 (100%), the names of all persons interviewed during the investigation; o In 10 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 10 (100%), all documents reviewed during the investigation; o In 10 (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; o In 10 (100%), the investigator's findings; and o In 10 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: In all three investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The report utilized a standardized format that set forth explicitly and separately ▪ In three (100%), each serious incident or allegations of wrongdoing; ▪ In three (100%), the name(s) of all witnesses; ▪ In three (100%), the name(s) of all alleged victims and perpetrators; ▪ In three (100%), the names of all persons interviewed during the investigation; ▪ In three (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; ▪ In three (100%), all documents reviewed during the investigation; ▪ In three (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 ▪ In three (100%), the investigator's findings; and ▪ In three (100%), the investigator's reasons for his/her conclusions. The presentation of information in the UIR was not always organized in manner that ensures all the details of this component of the SA can be readily identified to determine compliance. This can make it difficult for internal reviewers (e.g. RGSC program auditors, unit and facility IMRTs) to determine if each and every required topic has been addressed. The Facility had developed, and uses, an "Unusual Incident Investigation Review Checklist" to ensure each DFPS investigation, and each Facility investigation, adequately addresses each element of this component of this provision of the SA. This	

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		review is conducted by the Incident Management Coordinator and further reviewed by the Incident Management Review Authority comprised of the IMC, the Human Rights Officer, and the Director of the ICFMR Program. It may be useful to restructure how certain information is presented on a UIR to facilitate this review process and ensure its consistency and accuracy. Additionally, the Monitoring Team discovered that the State policy instructions that accompany the UIR, in some cases and if followed, would make compliance with this component of the SA very difficult. For example, the instructions for Section 5 of the UIR read, in part, "enter the name, title and shift of all staff who have relevant knowledge of the incident and/or who were or may have been present during the time the incident occurred. Do not routinely list all staff on the shift/home if they do not have relevant knowledge or investigative value." The Monitoring Team believes it would be difficult to determine if a particular staff person has relevant knowledge without at least requiring a staff statement and/or conducting an interview. The instructions for Section 7 in attachments to the DADS Incident Management policy read, in part, "Information from initial written statements of witness and/or interviews with staff members that reveal relevant information about the incident should be included here," and, "It is not necessary nor recommended that you summarize information received from each individual interviewed." This last statement is directly contrary to one of the requirements of this component of the SA.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The RGSC POI reported substantial compliance with this component of this provision of the SA and the Monitoring Team concurs. RGSC SOPs ICFMR 200-03 and 200-08 include specific requirements associated with this component of the SA. These policies require that staff supervising 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 Facility had developed, and uses, an "Unusual Incident Investigation Review Checklist" to ensure each DFPS investigation and report, and each Facility investigation and report, is thorough, complete, and accurate. The RGSC used its Corrective Action Plan process to ensure any deficiencies or areas of further inquiry in the investigation and/or report were addressed. 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.	Substantial Compliance

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		DFPS Investigations The following summarizes the results of the review of DFPS investigations: ▪ All 10(100%) DFPS reports reviewed contained evidence that the DFPS supervisor had conducted a review of the investigation report. ▪ In all 10 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. Facility Investigations The following summarizes the results of the review of Facility investigations: ▪ In all three investigation files reviewed there was evidence that the supervisor had conducted a review of the investigation report. ▪ In all three, 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 substantial compliance with this component of this provision of the SA and the Monitoring Team concurs. 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 was 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.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	The RGSC POI reported substantial compliance with this component of this provision of the SA and the Monitoring Team concurs. 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 was well organized and used by the IMC and the IMRT to ensure follow-up was 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 both planned and executed administrative activity.	Substantial Compliance
	(j) Require that records of the results of every investigation shall be maintained in a manner	The RGSC POI reported substantial compliance with this component of this provision of the SA and the Monitoring Team concurs.	Substantial Compliance

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	that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	Upon inspection by the Monitoring Team, investigation files were found to be easily accessible. A database was in place to enable an investigator to quickly identify individuals and staff who have been the subject of prior investigations. File storage at RGSC was organized and up-to-date. 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. If they do not maintain a database they can access this information from the Facility IMC.	
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The RGSC POI reported lack of compliance with this provision of the SA and the Monitoring Team concurs. In the last compliance report the Monitoring Team noted that neither the monthly Allegations Trend Report nor the monthly Unusual Incidents Trend Report reported 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. The outcome of DFPS investigations was also not delineated by type of case. The content of these trend reports had not been modified. Since DFPS reportable allegations and incidents tend 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. 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. The Monitoring Team provided this same suggestion in the last compliance report.	Noncompliance
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	The RGSC POI reported substantial compliance with this provision of the SA and the Monitoring Team concurs. 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	Substantial Compliance

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	investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	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. 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. 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. The Facility reported it did not have any volunteers who regularly work with Individuals. Students assigned to clinical rotations at RGSC undergo the same background checks as employees and documentation to validate this was provided to the Monitoring Team.	

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

1. DFPS needs to improve the timeliness of initiating its investigations and to document all activities that may demonstrate investigations begin within required timelines (D.3.e).
2. Data elements included in trend reports need improvement minimally to further delineate type of DFPS case and to display rolling 12 month trend data (D.4).
3. Staff training and competency checks need more emphasis to improve staff knowledge in responsibilities for reporting (D.2.a).
4. The Facility needs to improve its practices with regard to the review of discovered injuries to rule out abuse or neglect as the cause, or a contributing factor (D.2.a).
5. Injury under-reporting audits need to be conducted in a consistent manner (D.3.i).

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** 1. RGSC Plan of Improvement (POI) updated 8/9/11 2. SA-PIC meeting minutes 3/2/11, 4/27/11, 5/26/11, and 7/21/11 3. RGSC SOP QM 100.014 DADS Quality Enhancement Expectations 6/11 4. RGSC Improving Organizational Performance Program 6/11 5. RGSC Quality Management Manual: Staff Composition and Responsibility 6/11 6. RGSC Monitoring Tools and Summary Report (undated) 7. RGSC Trend Analysis Report June, 2011 8. Corrective Action Plan (CAP) Reporting 2011 from April thru Present 8/24/11 9. Sample of completed SA monitoring tools 10. Customer Satisfaction Survey Family Members of Persons Served at the State Center (9/10) 11. Incident Management Review (IMRT) minutes for 15 meetings from 3/1/11 to 8/22/11 12. Self-Advocates meeting minutes 3/1/11, 4/13/11, 5/24/11, 6/14/11, 7/12/11, and 8/23/11 13. Under Reporting Record Review 6/8/11 and 7/15/11 14. UIR Audits 4/5/11(2x), 5/25/11(2x), 6/15/11 (2x), 7/11/11 and 8/12/11(2x) 15. DADS injury data report comparing facilities 8/23/11 **People Interviewed:** 1. Mary Ramos, Quality Management Director 2. Lorraine Hinrichs, ICF-MR Program Director 3. Rosie Sanchez, QE Coordinator 4. Alondra Machado, Data Analyst 5. Megan Gianotti, Psychology Manager 6. Myrna Wolfe, Incident Management Coordinator 7. Janie Villa, QMRP Manager **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 8/22/11 2. Settlement Agreement Performance Improvement Council (SA-PIC) 8/24/11 3. Self-Advocate Meeting 8/23/11
	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. RGSC had improved its QA processes but did not feel these processes had been in place long enough to demonstrate consistent implementation and outcomes. As a result, the Facility indicated a self-assessment of substantial compliance was not warranted. The Facility had taken steps forward from what the Monitoring Team observed during the last compliance review. Improvements made in the Corrective Action Plan (CAP) tracking system, especially in evidence documentation, were most noticeable. The Facility continued to track a significant amount of data but improvements are needed in data

	organization and presentation to make it useful for analysis and process improvement decision-making. The process for data analysis was improved from that observed at the last compliance review. The Facility developed a simple straight-forward approach to guide different work teams in their analysis of data. This process requires review teams to check (C) the data, ask (A) questions about what the data is suggesting, think (T) about opportunities for improvement, talk about why (W) we are contemplating certain corrective action (in the context of the data), and what (W) can be done about the problem the data identifies. This process was regularly used, documented on a special form, and referred to as CATW^2.
	Summary of Monitor's Assessment: The Facility had initiated many of the administrative activities that will be necessary to achieve compliance with this section of the SA. These were noted in the POI and included the following: The Facility implemented the use of the Statewide Monitoring Tools Database with findings reported to the SA-PIC; developed a strategy to better analyze data, referred to as CATW^2 , Check, Ask, Think, Why, and What; assigned quality advisors for each SA section team and began training teams/committees on CATW^2 ; used CATW^2 to analyze Trend Analysis Reports; updated the Corrective Action Plan (CAP) form to include date CAP initiated, monitoring frequency and type of evidence to be submitted; initiated a monthly report for SA-PIC of CAPs initiated and CAPs completed; and, developed a QA plan which includes who, or which SA section team, initiates a CAP and which team monitors the completion of the CAP. The Monitoring Team observed improvements in the QA process from that noted in the last compliance report. Data reports are better organized and labeled. 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. Since the last review the RGSC had developed a written Quality Assurance Policy and Plan. The Plan is comprehensive and ample evidence exists that demonstrates the plan is being implemented. Many CAP's resulted from plan implementation. These CAPS were tracked and not closed until evidence was collected and provided to the QA Department to validate completion. The process for data analysis was improved from that observed at the last compliance review. The Facility developed a simple straight-forward approach to guide different work teams in their analysis of report data. This process requires review teams to check (C) the data, ask (A) questions about what the data is suggesting, think (T) about opportunities for improvement, talk about why (W) we are contemplating certain corrective action (in the context of the data), and what (W) can be done about it . This process was regularly used, documented on a special form, and referred to as CATW$^{2.}$. The Monitoring Team believes a Quality Assurance and Corrective Action Planning process should include two different sets of activities and strategies for outcomes: 1. Development of specific actions necessary to correct specific problems discovered through monitoring and auditing conducted by residential units and facility departments, and by Program Auditors in the QA Department.

	2. Development of broader strategic action plans to correct systemic problems identified through the analysis of data collected over time from a variety of sources, such as: the results of monitoring/auditing referenced above; tracking and trending data described in E1; regulatory reports (CMS 2567's); reports (anecdotal and written) coming from DADS subject matter experts, outside consultants, DFPS, OIG, and others; and, data collected from self-advocacy group meetings, family member meetings, and other stakeholders. The QA activity in place at RGSC consisted largely of administrative steps directed at this first strategy. The Monitoring Team did not observe any activity directed at the second strategy. The Monitoring Team suggested to the RGSC QA Director that the Facility may want to consider coding CAPS in a way that allows CAPS that target similar types of problems to be summarized in separate reports. This could facilitate a process where CAP data associated with similar types of problems could be reviewed looking for systemic issues needed attention, and, to determine if previously completed CAP activity has met the desired outcome of remedying or reducing the problems originally identified.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	The RGSC POI reported lack of compliance with this provision of the SA and the Monitoring Team concurs. RGSC had improved its QA processes but improvement in tracking, trending, and use of data is still necessary. Data being tracked met the minimal requirements of the SA in many respects but were deficient in some important areas. As noted in the last compliance report, RGSC produced a monthly Allegations Trend Report and a monthly Unusual Incidents Trend Report. Neither report provided data over time on DFPS reportable incidents by type, e.g. physical abuse, verbal abuse, or neglect; these were provided only for the current month, such that trends would be difficult to track. 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. Data reported in these trend reports had not been restructured since the last review. The POI did not report any activity directed at this needed improvement. Since DFPS reportable allegations and incidents tend 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 can be used for facility analysis and process improvement decision-making. 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. As noted in the last compliance report, this provides a snapshot of the current month; however, these data are not trended over time, such as a	Noncompliance

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		rolling 12-month period. The Monitoring Team believes they must be in order to identify trends, as required to achieve compliance with this provision of the SA. The RGSC had established a Settlement Agreement Program Improvement Council (SA-PIC). This group meets monthly. The Monitoring Team reviewed meeting minutes and observed a meeting during the review. The Trend Reports and other data were presented. Much of the meeting consisted of information being presented by SA section team leaders. Some presenters also included observations of what they thought the reported data might suggest with regard to improvements in operational practices. There was some discussion directed at interpreting the data in a manner that could stimulate change in policy or practice; however, the Monitoring Team noted only a few Corrective Action Plans being discussed as a result of the SA-PIC review. None of the discussion focused on systemic issues and corrective actions necessary to address systemic issues. To its credit, the RGSC established two trend reports not required by State office but important to analyzing situations needing improvement. These two trend reports track falls and incidents of peer-to-peer aggression. These are important topics to track and trend as the number of falls, and the number of injuries related to peer-to-peer aggression, are significant and contribute to RGSC having the highest injury rate (as reported by DADS) of any of the SSLCs/State Centers. Since the last review the RGSC had developed a written Quality Assurance Policy and Plan. The Plan is comprehensive and ample evidence exists that demonstrates the plan is being implemented. Many CAP's resulted from plan implementation. These CAPS were tracked and not closed until evidence was collected and provided to the QA Department to validate completion. The Monitoring Team believes a Quality Assurance and Corrective Action Planning process should include two different sets of activities and strategies for outcomes: 1. Development of specific actions necessary to correct specific problems discovered through monitoring and auditing conducted by residential units and facility departments, and by Program Auditors in the QA Department. 2. Development of broader strategic action plans to correct systemic problems identified through the analysis of data collected over time from a variety of sources, such as: the results of monitoring/auditing referenced above; tracking and trending data described in E1; regulatory reports (CMS 2567's); reports (anecdotal and written) coming from DADS subject matter experts, outside consultants, DFPS, OIG, and others; and, data collected from self-advocacy group meetings, family member meetings, and other stakeholders.	

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		The QA activity in place at RGSC consisted largely of administrative steps directed at this first strategy. The Facility developed a useful straightforward approach to help guide different work teams in their analysis of data. This process requires review teams to check (C) the data, ask (A) questions about what the data is suggesting, think (T) about opportunities for improvement, talk about why (W) we are contemplating certain corrective action (in the context of the data), and what (W) can be done about it . This process was regularly used, documented on a special form, and referred to as CATW^2. The Monitoring Team did not observe any activity directed at the second strategy. The Monitoring Team suggested to the RGSC QA Director that the Facility may want to consider coding CAPS in a way that allows CAPS that target similar types of problems to be presented in separate reports. This could facilitate a process where CAP data is reviewed looking for systemic issues needed attention, and, to determine if previously completed CAP activity has met the desired outcome of remedying or reducing the problems originally identified.	
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) responsible; and the time frame in which each action step must occur.	The RGSC POI reported lack of compliance with this provision of the SA and the Monitoring Team concurs. RGSC had improved its QA processes but did not feel these processes had been in place long enough to demonstrate consistent implementation and outcomes. As a result, the Facility indicated a self-assessment of substantial compliance was not warranted. Additionally, the level of data analysis undertaken by the Facility was not yet sufficient to identify systemic trends that need substantive corrective action. The RGSC had established a Settlement Agreement Program Improvement Council (SA-PIC). As noted in Provision E.1, the Monitoring Team reviewed meeting minutes and observed a meeting during the review. Although there is potential for this group to identify systemic issues and develop CAPs and improvement initiatives to address the issues, discussion did not yet focus on such issues. A process for the development and implementation of Corrective Action Plans was in place. In its present form it sets forth plans that address specific isolated events. Plans reviewed by the Monitoring Team addressed an action to correct the specific problem that was identified for correction but did not usually include actions designed to prevent the recurrence of the same problem. Nearly all problems were determined to be the result of a single error of one type or another. There was no evidence that this process attempted to identify issues of a systemic nature that would require 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 at RGSC. The Monitoring Team suggested to the RGSC QA Director that they may want to consider coding CAPS in a way that allows CAPS that target similar types of problems to be presented in a unique report. This could facilitate a process where CAP data is reviewed	Noncompliance

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		looking for systemic issues needing attention, and, to determine if previously completed CAP activity has met the desired outcome of remedying or reducing the problems originally identified.	
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. RGSC had improved its QA processes, including dissemination of CAPs, but reported it could not demonstrate that all CAPS were disseminated to all entities responsible for their implementation in a consistent and timely manner. As a result, the Facility indicated a self-assessment of substantial compliance was not warranted. Improvements to the corrective action plan process that went into effect in November, 2010 were noticeable to the Monitoring Team. Samples of CAP documentation were reviewed by the Monitoring Team and in most cases the required evidence was present. Individual CAPs, which usually address single 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, especially if implementation requires action from multiple departments, is occurring. The CAPs usually identified one person responsible for implementation. The Monitoring Team could not ascertain from available documentation if other staff also received a copy of the actual CAP even though the substance of the needed corrective was usually discussed at an IMRT meeting. Many CAPs were not completed within their assigned timeframe. For example, in reviewing completed CAPs from 7/15/11 to 7/31/11, 57% (16 of 28) were not completed timely. One reason for this could be that not all staff who needed to be involved in the corrective action received the CAP.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	The RGSC POI reported lack of compliance with this provision of the SA and the Monitoring Team concurs. RGSC had improved its QA processes but did not feel these processes had been in place long enough to demonstrate consistent implementation and outcomes. As a result, the Facility indicated a self-assessment of substantial compliance was not warranted. Improvements to the corrective action plan process that went into effect in November, 2010 were noticeable to the Monitoring Team. Samples of CAP documentation were reviewed by the Monitoring Team and in most cases the required evidence was present. Some did not contain an entry in the "evidence received" section of the report. Consistent documentation in these reports is needed. Many CAPs were not, however, completed within the timeframe assigned at the time of	Noncompliance

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		CAP initiation. For example, in reviewing completed CAPS from 7/15/11 to 7/31/11, 57% (16 of 28) were not completed timely. The Facility was unable to describe any process to determine if a CAP was effective in remedying or reducing the problems originally identified. To achieve compliance, the Facility must maintain the improvements made, ensure most CAPs are completed within assigned timeframes or that there is documentation of status reports, and gather and report information (including data when appropriate) to evaluate whether the CAP was effective in remedying or reducing the problems originally identified and is revised if not effective.	
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. RGSC had improved its QA processes but did not feel these processes had been in place long enough to demonstrate consistent implementation and outcomes. As a result, the Facility did not feel a self-assessment of substantial compliance was warranted. The Facility reported its process to modify CAPs was informal, usually consisting of dialogue between someone assigned to implement a CAP and someone in the QA Department responsible for collecting evidence of completion. The Monitoring Team was not provided anything which could serve as documentation of this process. Nothing in the Facility policies addressed this subject. Additionally, it did not appear that the Facility had a process to determine if a CAP was effective in remedying or reducing the problems originally identified or needed to be revised.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:
1. Refine the trend reports to provide more data and array the data in a more useful manner for analysis, particularly in identifying systemic issues.
2. Improve the corrective action plan process, including the tracking of effectiveness.
3. As appropriate based on trend data, select and implement additional process improvement initiatives.

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement (POI) 8/9/11 2. DADS Policy 004 Personal Support Plan Process 7/30/10 3. RGSC SOP MR 600 01 Personal Support Plan Process (Integrated Protections, Services, Treatments, and Supports) last revised 4/11 4. RGSC SOP MR 600 02 Development and Monitoring of Individual Program Plans Personal Support Team Approach last revised 2/10 5. Corrective Action Plan Report 8/24/11 6. QMRP Check Sheet for Personal Support Plan Process 7/23/10 7. Sample Personal Support Plan Meeting/Documentation Monitoring Checklists 8. Sample QMRP Engagement Monitoring Form 8/2/11 9. PSP Sample 1: PSPs for Individuals #5, #27, #47, #61, #77, #107, #133, and #140 10. PSP Sample 2: Personal Support Plans (PSPs) and related documents for Individuals #5, #47, #54, #61, #98, #133, and #149 11. Personal Focus Assessments (PFAs) for Individuals #5, #27, #47 and #133 12. Section F Monitoring Tools 13. Q Construction: Facilitating for Success training curriculum 14. Personal Focus Assessment (PFA) for Individuals #47, #133, and #140 15. Customer Satisfaction Survey Family Members of Persons Served at the State Center (9/10) 16. Self-Advocates meeting minutes 3/1/11, 4/13/11, 5/24/11, 6/14/11, 7/12/11, and 8/23/11 17. List of PSP dates by Individual (undated) 18. ICF Monthly Delinquent Assessment Report for 5/1/11-6/30/11 19. Assessment folder on Share Drive for Individual #91 **People Interviewed:** 1. Mary Ramos, Quality Management Director 2. Rosie Sanchez, QE Coordinator 3. Lorraine Hinrichs, ICF-MR Program Director 4. Janie Villa, QMRP Manager 5. Megan Gianotti, Psychology Manager 6. Joint interview of all QMRPs **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 8/22/11 *2.* Settlement Agreement Performance Improvement Council (SA-PIC) 8/24/11 *3.* Personal Support Plan (PSP) meeting for Individual #140 *4.* Risk meetings for Individuals #40 and #80 5. Quarterly PSP Review meeting for Individuals #39 and #74
	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 review. One method RGSC could use to assess compliance with some components of this provision would be data analyzed from the PSP Monitoring Checklist. The Monitoring Team asked for all PSP monitoring checklists from 3/1/11 to date and was provided with checklists for one PSP in March, two in July, and one in August. Some PSP meetings held since 7/13/11 were not monitored as described in the POI. Additionally, there was no evidence that these data were used in determining self-assessment compliance ratings. 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 instead many cases in which services were not integrated or were not established as actions in the PSP. 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: 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. 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. 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; the most recent assessments revealed modest progress was achieved toward ensuring that adequate assessment scores for cognitive ability and adaptive skills were included in reports but did not fully comply, and not all documented interpretation of assessment findings. 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. Assessment when there was a change in status for an individual also was variable. 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. Review of structural and functional assessments revealed improvement but not yet compliance. The Facility did not address obstacles to movement to a more integrated environment adequately. Obstacles were identified that could be made available by other providers, and strategies to overcome obstacles were not addressed in many PSPs. 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. The structure of an interdisciplinary team process was in place at RGSC but most Interdisciplinary Team (IDT) interaction was multidisciplinary. Observation at the one PSP planning meeting held during the week of the review demonstrated improvement in interdisciplinary discussion. Still, discussion at these meetings relied primarily on reports by disciplines of their impressions without providing data and other information that would encourage more informed interdisciplinary decision-making. 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. 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	Noncompliance

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		detail.	
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs. The PSP process observed by the Monitoring Team was led by a QMRP, and each PSP reviewed by the Monitoring Team documented QMRP responsibility. QMRPs use a "QMRP Check Sheet for Personal Support Plan Process" to ensure policy requirements associated with PSP development are addressed. The RGSC increased the number of QMRPs since the last review so that four QMRPs provide services to the 71 Individuals living at RGSC. One of these four QMRPs is designated as the lead QMRP and maintains a caseload similar in size to the other three. QMRPs had completed the newest training offered by DADS, "Q Construction: Facilitating for Success" and two had their facilitation skills evaluated by the Facility's QMRP Manager. The documentation (QMRP Facilitation Skills Performance Tool) to measure QMRP facilitation skills was not fully completed and the Monitoring Team could not ascertain whether the QMRPs being evaluated were deemed competent in facilitation. 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 usually did not describe the information when giving impressions. This information could be helpful to other PST members in provide insight and perspective leading to better decisions. 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 #74, there was good participation by the PST members, including the individual, the Speech and Language Pathologist (SLP), nurse, psychologist, and active treatment specialist. The SLP and QMRP assisted the individual to use a communication book to answer questions, including about the individual's preference for	Noncompliance

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		job training; for that issue, the PST assigned the active treatment specialist to provide opportunities for the individual to sample jobs and to assess job preference, while the SLP and psychologist will begin developing a communication dictionary (so that staff know what the individual's communications mean). There was also a discussion about the need for more outings to provide an opportunity to learn to make purchases; the SLP asked to be informed of an outing in advance so that picture cards could be developed in advance for use during the outing. These were excellent examples of interdisciplinary and integrated planning; the Monitoring Team will need to review, at future compliance visits, whether such planned actions are actually implemented. Clinicians looked at and appeared to review documents and then report impressions but did not provide data. For example, at the Quarterly PSP review meeting for Individual #39, the PST referred to both the Active Record and the Client Work Station (CWS—the electronic record) for information about appointments and follow-up. At the review for Individual #74, the PST referred to both the Active Record and CWS to review seizure information; unfortunately, the seizure data were not updated in the record daily, so current month data were not available for discussion. 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 #140, the Monitoring Team completed the checklist. Some of the items rated included: • The PSP meeting was scheduled according to the person's preferences (to make possible participation by the individual's family). • PST members actively participated in the meeting. • Preferences were not prioritized during the meeting. Therefore, It was unclear whether high priority preferences were addressed in action plans. • The PST discussed whether there was a need for communication devices. • The PST discussed psychotropic medications. • The person's legal status was reviewed. • The team did not fully incorporate any PBSP in the action plan; there was discussion of adding use of tokens but replacement behavior training was not identified. • There was discussion of rights and abuse/neglect policies with the individual and her LAR, who was present at the meeting including reporting. 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.	

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F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	The RGSC POI reported lack of compliance with this component of this provision of the SA and the Monitoring Team concurs. PSP annual planning and quarterly review meetings had begun to include the participants required. Because assessments were not always timely it was often difficult to determine if appropriate disciplines were represented at PSP meetings. Five of seven (71%) PSPs provided in response to document requests included sign-in sheets. The Monitoring Team therefore could not confirm that all required participants attended PSP meetings. However, for the five PSPs that included sign-in sheets and for the observed PSP annual meeting for Individual #140 and PSP Quarterly Reviews for Individual #39 and #74, the QMRP, individual, Psychiatric Nurse Assistant direct care professional (DCP), and other persons apparently relevant to the individuals' preferences and needs were present. 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. For one of three (33%) 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. PST member involvement in development of supports and treatments was not always evident. There was some evidence that participation of Direct Care Professionals in the 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 regularly and 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. 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	Noncompliance

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		input from the PST with an emphasis on DCPs, medical/nursing staff, and behavioral staff (if appropriate). Records did provide evidence in the PSPs that the PNMPs were included, but there was no evidence of discussion or input from other team members. It was encouraging to note the participation of Individual #79 in the Quarterly PSP review and of Individual #140 in the PSP annual review. In both cases, active engagement by the individuals was promoted, and their responses to questions were considered during planning.	
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. Similar to what was observed in the last compliance review, there was variability in the presence, timeliness, quality and the comprehensiveness of assessments Based on review of individuals with changes in status as reported in Provision P.1, there was not an assessment or review as indicated by a change in the individual's status or as dictated by monitoring results. • Individual #54 was diagnosed with aspiration pneumonia on 4/21/11 but there was no evidence of reassessment upon return or discussion of the event by the PST. There was discussion by the PNMT but this did not occur until 5/5/11. • Individual #19 was diagnosed with aspiration pneumonia on 7/25/11 but there was no evidence of reassessment upon return or discussion of the event by the PST. There was also no discussion by the PNMT at the 8/3/11 meeting. • Individuals #15 and #93 experienced multiple falls over the period ranging from April to July 2011 but there was no evidence of assessment or review by the PT or PNMT. The Monitoring Team reviewed nine psychiatric evaluations. The Monitoring Team determined that the psychiatric evaluations reflected the Facility's procedure and were well within expected standard of care 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. Review of structural and functional assessments revealed improvement but not yet compliance. 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; the Facility had	Noncompliance

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		contracted with two consultants to complete assessments of cognitive ability and adaptive behavior as a way to complete more psychological assessments. The most recent assessments revealed modest progress was achieved toward ensuring that adequate assessment scores for cognitive ability and adaptive skills were included in reports but did not fully comply, and not all documented interpretation of assessment findings. 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. All individuals had received an OT/PT assessment. If newly admitted, this occurred within 30 days of admission (Sample #6). The assessments submitted were completed by both OT and PT. However, as reported in Provision P.1, review of individuals with changes in status did not provide evidence of assessment or review as indicated by a change in the individual's status or as dictated by monitoring results. Furthermore, as reported in Provision O.2, individuals did not receive comprehensive assessments on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake. Although communication assessments were being done, they were neither detailed nor comprehensive enough to allow for the identification and potential expansion of communication skills. All individuals admitted since the last compliance visit received a communication assessment within 30 days of admission.	
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. Assessments must be timely in order for them to be used in developing integrated services and supports in a PSP. The Monitoring Team identified numerous instances where assessments were not done timely. For example, for the PSP for Individual #47 only five of ten (50%) required assessments were done prior to the date of the PSP meeting. For Individual #133, only six of ten required assessments were done prior to the date of the PSP meeting. There was no situation in which an assessment was comprehensive and appropriate to a change in status or at the time of an annual assessment by the OT/PT or by the SLP. The Facility had initiated an ICF delinquent assessment review process. The Monitoring	Noncompliance

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		Team reviewed data regarding compliance of assessments from 5/1/11 through 6/30/11. The Monitoring Team did not review the definition of "compliance" but was of the understanding that this referred to being in the Active Record or CWS timely per Facility policy. The Monthly Delinquent Assessment Report broke down the assessments by discipline. Compliance ranged from 46% of QMRP assessments in June to 100% of Rights and Nutrition assessments in both May and June. The Monitoring Team reviewed the assessments on the Share drive for Individual #91, who was to have a PSP annual planning meeting four days later, to see whether assessments were present (to meet the facility policy requirement of being posted on the Share drive 10 days prior to the annual PSP planning meeting); six of 14 (43%) of assessments were posted. The QMRP reported that one additional assessment had been done but was not posted yet. The Monitoring Team does not have a way to reconcile the information in this section (from review of PSPs and the single individual whose assessment reports in the Share Drive were checked) against the much higher figures for compliance in the Monthly Delinquent Assessment Report but suggests the Facility make an attempt to reconcile these or determine why they result in a significant variance in findings; then the Facility needs to ensure its process to monitor timeliness of assessments produces accurate and useful information. Further evidence of untimely assessments was provided through Active Record Audits. When these audits identified missing or overdue information a Corrective Action Plan (CAP) was initiated. In reviewing a report of "open" CAPS dated 8/24/11 there were many instances of missing assessment and related information. For example, CAP 511.3 and 511.6 both reported missing or overdue information as follows: QMRP social services assessment, rights assessment, personal focus assessment, safety assessment for water activities, integrated risk rating form, QMRP quarterly review, and Community Living Options Information Process (CLOIP). CAP 505 reported an overdue psychiatric evaluation. CAP 510 reported an overdue psychological evaluation. CAP 622 reported as missing or overdue the psychological assessment and structural and functional assessment. Other than the audits and the tracking of assessments to be placed on the Share drive, the Facility was unable to present a process for monitoring assessment due dates and completion to the Monitoring Team. It was reported that the Facility would begin using a DADS assessment tracking data base beginning in September, 2011. The Monitoring Team was unable to confirm with DADS staff onsite the existence of the referenced data base. Although data and information from many 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	

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		members of the PST, for some issues, asked questions and added information, and discussed the summaries and impressions of the clinicians.	
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. 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. The Living Options discussion was thorough. Supports needed included tours of group homes and discussion of supports the individual would need both for visits and for successful living. Based on the PSP developed at the 2010 annual planning meeting, this individual was given the opportunity to stay for several days more than one time at a possible home; she chose not to move to that home. The PST discussed and agreed to additional exploration of other providers to attempt to find one that will be satisfactory to the individual. The Monitoring Team reviewed PSPs of PSP Sample 1 (Individuals #5, #27, #47, #61, #133, and #140) to sample whether PSPs were developed in accordance with requirements of this provision. Two of these six PSPs reviewed (33%) included specific plans relevant to movement to a more integrated environment. As an outcome of PSP planning, Individual #140 was referred for a move. The individual had made two three-day visits and one ten-day visit to a specific home prior to the last compliance visit; at the end of the ten-day visit, the individual stated she wanted to continue to live at RGSC. During the individual's annual PSP planning meeting held during the current visit, the decision was made to continue visits to other homes so as to find an setting that would be acceptable to the individual. Personal Focus Assessments (PFAs) were reviewed for Individuals #5, #27, #47 and #133. For two of these four PFAs (50%), the PFA identified a preferred living environment; in both cases, that environment was RGSC. For the other two, as reported for Provision T.1.b.1, there were multiple documents with varying reports of preferred living environments and no evidence of attempts to reconcile the different reports in order to determine what preference for a living environment would provide the basis for PSP planning. As reported in Provision T.1.b.1, obstacles to movement to a more integrated environment were listed in PSPs that could routinely be made available by other providers. PSPs did not consistently address strategies to overcome obstacles to movement.	Noncompliance

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		For five of the six PSPs reviewed (83%), the PSP stated the most integrated setting was RGSC. 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. It was not clear whether the professional members made determinations separate from the preferences of the individual or LAR. This provision is discussed in detail later in this report with respect to the Facility's progress in implementing the provisions included in Section T of the Settlement Agreement.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		Noncompliance
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs. The revised Supporting Visions PSP policy had been 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. A PSP had been developed for each individual. Per Monitoring Team review of a sample of PSPs for PSP Sample 1 (Individuals #5, #27, #47, #61, #133, and #140), the PSPs did not yet meet the requirements of this provision. The Monitoring Team reviewed the supports identified as needed. All PSPs (100%) listed supports that would be needed in the most integrated setting. As noted in the last compliance report and reported in Provision T.1.b.1, 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	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>provide explanations for needs or barriers not addressed.</td><td></td></tr>
<tr><td></td><td>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;</td><td>The RGSC POI reported lack of compliance with this component of this provision of the SA and the Monitoring Team concurs.

Observable and measurable goals/objectives, treatments and strategies, and necessary supports to attain identified outcomes should be identified in the Action Plans in the PSP. However, 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. Furthermore, descriptions of goals and objectives in the Action Plans in the PSPs were brief and not descriptive. For example, for Individual #149, the following goals were listed:

<table><tr><th>Action Plan Desired Outcome</th><th>Measurable Steps-Training/Service Objectives</th></tr><tr><td>1: To increase level of independence</td><td>• Dinning (sic)-Alternate fluids and liquids
• SAMS</td></tr><tr><td>2: To increase independence</td><td>• Grooming
• Oral Hygiene</td></tr><tr><td>3: Maintain healthy weight</td><td>Physical fitness</td></tr><tr><td>4: Increase money management skills</td><td>Money management</td></tr></table>
The PSP Integrated Discussion section reported the individual had a Positive Behavior Support Plan (PBSP) for challenging behavior, but the PBSP was not listed in the Action Plans, nor were measurable objectives described related to the challenging behaviors.

Furthermore, other supports and services were provided without specification of measurable objectives, and assessments of progress did not include summarization of data.
• For Individual #5, the nursing summaries did not describe progress toward weight management goals and objectives. None (0%) of the Section XI nursing summaries were adequate to effectively demonstrate individuals' heath status related to their identified nursing problems/diagnoses in terms of progress</td><td>Noncompliance</td></tr>
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		made toward the problems' established goals and objectives. • While PNMPs are reviewed at the PSP, there was not a system fully in place that clearly monitored the effectiveness of the plan by tracking clinical indicators for all individuals who are determined to be at an increased risk such as the occurrence or absence of triggers (signs and symptoms associated with physical and nutritional decline that require staff response). • As reported in Provision K.3, all sampled PBSPs included operational definitions of target behavior. However, only 50% of sampled PBSPs included operational definitions of replacement behaviors. None included a description of data collection procedures. • Communication goals were, in general, not measurable and did not consistently address the needs of individuals.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs. The Facility had not yet integrated all protections, services, supports, and plans provided for individuals, as the following examples demonstrate. Numerous examples are provided throughout this report regarding how plans, supports and services were not integrated through the PSPs. PSPs appeared to integrate some, but not all protections, services and supports that individuals required, as this provision of the Settlement Agreement clearly requires. In seven of seven (100%) PSPs reviewed by the Monitoring Team for this purpose (PSP Sample 2), the Action Plans involved separate services or goals with no indication of integration of interventions. For example: • For Individual #149, the importance of work and a significant speech disorder (and use of communication device) were identified, but there was no vocational goal or evidence that communication during vocational training would be addressed. There was little evidence of integration of supports seen during observations. As documented in the findings for Provision R3, individuals who had communication devices were not observed using them in any area. Furthermore, during observations in the Vocational Rehabilitation area, there was no utilization of communication boards by individuals nor was encouragement to use such devices observed. 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	Noncompliance

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		opportunity for generalization and/or acquisition of skills. Habilitation interventions and/or strategies were not consistently integrated into the PSP. For example: • Individual #140's OT/PT assessment provides methods in which to improve stability but these strategies were not mentioned in the PSP and were not integrated into the service objectives • Individual #143's PSP simply stated to continue PNMP and did not provide information regarding contents of the PNMP Although the Psychiatrist was providing exceptional clinical reviews to determine the need for psychotropic medications and ensuring that psychotropic medications are well justified, the PST process was not fully involved. 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. Psychiatrists did not consistently participate at PST meetings to discuss these issues. 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. Interventions and/or strategies were not consistently integrated into the PSP. For example: • Individual's OT/PT assessment provides methods in which to improve stability but these strategies were not mentioned in the PSP and were not integrated into the service objectives • Individual #143's PSP simply stated to continue PNMP and did not provide information regarding contents of the PNMP. 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.	
	4. Identifies the methods for implementation, time frames for completion, and the staff	The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs.	Noncompliance

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	responsible;	As noted for Provision component F2a2, methods for implementation were not clearly specified. For six of seven (86%) 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.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs. 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. 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. 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.	Noncompliance
	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.	The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs. 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. In many cases, the data collection strategy had been tailored to the specific nature of the individual's behavior. However, as reported in Provision K.4, although there was improvement in data collection, there were still substantial limitations in the quality of behavior data collected. Furthermore, in several documents, data did not reflect improvement following a change in treatment, or even demonstrated worsening behavior, without evidence of an effort to revise the treatment.	Noncompliance

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F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs. 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 facilitate team discussion focusing on integrated planning in the PSP meeting. Action Plans for seven of seven (100%) PSPs reviewed did not include all areas of planning or intervention identified in assessments or needed to address obstacles to movement to a more integrated setting.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs. 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. For example, Positive Behavior Support Plans (PBSPs) and nursing care plans were not routinely included in Action Plans and were not always described in PSPs. 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. PSPs were also accessible in the Individual Notebook found in both the living and day activity areas. PBSPs were evaluated for readability. Both readability statistics and interviews indicated they were comprehensible to staff responsible for implementation. Although PNMPs and PBSPs were available and readable, they were not followed. Therefore, it will be important for the Facility to provide competency-based training and monitoring to ensure that what appears comprehensible on paper actually provides the guidance needed for accurate implementation.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with	The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs.	Noncompliance

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	full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	There were numerous examples in which review of progress should have indicated the need to revise programs or ensure implementation. 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 many cases that showed that the strategy had been tailored to the specific nature of the individual's behavior. Although there were improvements in collection of behavioral data, there were substantial limitations in the quality of data collected. Furthermore, as reported in Provision K.4, many progress notes reflected failure to use available data in making treatment decisions. As reported in Provision R.3, communication devices planned for individuals were not implemented and used. There were not reviews by the appropriate PST member or QMRP to ensure these were implemented.	
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	The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs. 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. QMRPs had completed the newest training offered by DADS, "Q Construction: Facilitating for Success" and two had their facilitation skills evaluated by the Facility's QMRP Manager. The documentation (QMRP Facilitation Skills Performance Tool) to measure QMRP facilitation skills was not fully completed and the Monitoring Team could not ascertain whether the QMRPs being evaluated were deemed competent in facilitation. The observed PSP annual planning meeting and Quarterly Reviews, while they did involve substantial participation from numerous staff and the individual, did not use assessment information in making decisions. As monitoring of application of facilitation and of the PSP process continues, and as QMRPs and the rest of the PST gain experience with the process, the Monitoring Team would expect continuing development of PST skills in planning. 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.	Noncompliance

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	revised.	Provision of competency-based training on the implementation of individuals' plans was not routine. For example: • It was positive to find documentation that the nursing staff had consistently trained the direct care professionals on their respective responsibilities on individuals HMPs and ACPs. A review of HMPs and ACPs showed that the nursing staff had developed, implemented, and trained direct care professionals on the special instruction sheets for each of the care plans. • Staff were provided initially with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff. However, there was not a clear process that ensured staff (including pulled staff) received training prior to working with individuals who were identified as being at increased risk of aspiration or when there had been a change in health status. • Although RGSC had initiated attempts to assess staff competence in relation to PBSPs prior to the last compliance visit, PBSPs were not implemented consistently. The Monitoring Team did not observe any staff implement a formal PBSP even when circumstances warranted implementation. • Staff were not trained in the use of the AAC or knowledgeable of the communication strategies of individuals on their homes. The RGSC POI reported that as of 7/13/11 QMRPs began monitoring DCPs to determine, among other things, their comprehension of the PSP. The documentation provided to the Monitoring Team to validate this process was an "Engagement Monitoring Form (8/2/11)" which did not include any probes relevant to understanding the PSP but instead reported whether DCPs were actively engaged with individuals and whether individuals were engaged in activity.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs. Two individuals had been admitted to the Facility since the prior compliance visit. Both had an initial PSP meeting within 30 days of admission. The Facility was asked to prepare a list comparing, for each Individual, the dates of their last two PSP meetings, and, the date the most current PSP was put into effect. The Facility reported that the "put into effect" date should be considered the date the PSP was finalized and submitted to Health Information Management (HIM). A review of this information prepared by the Facility showed the following: 1. Five current PSP meetings were not held within 365 days of the previous meeting. This was the case with Individuals #48, #79, #29, #77, #59. All but Individual #59 were only one day late.	Noncompliance

#	Provision	Assessment of Status	Compliance
		2. Most PSPs were not put into effect within 30 days of the PSP meeting. Fifty-one of 71 (72%) did not meet the documentation requirement (PSP submitted to HIM) to comply with this requirement. This included the two new admissions. The Facility provided other evidence to demonstrate that at least some elements of a PSP were put into effect within 30 days. This consisted of in-service sign-in sheets showing staff training on Specific Program Objectives (SPOs) and in some cases data sheets validating implementation. The Facility needs to establish a more formal, and accountable, methodology to measure compliance with this component of the SA.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The RGSC POI reported lack of compliance with this component of this provision of the SA and the monitoring team concurs. The Facility reported that it had begun to use the monitoring checklist for PSP meetings provided by DADS. The POI stated that review of PSP meetings would begin in March, 2011and that as of 7/13/11 the QMRP Manager and Lead QMRP would be monitoring 100% of PSP meetings. The Monitoring Team asked for all PSP monitoring checklists from 3/1/11 to date and was provided with checklists for one PSP in March, two in July, and one in August. Some PSP meetings held since 7/13/11 were not monitored as described in the POI. None of the monitoring checklists included specific actions needed to correct issues identified during the monitoring observation. None indicated a CAP had been initiated. The Facility had not begun to identify and trend findings from monitoring but expected to begin reporting findings to the SA-PIC in September, 2011.	Noncompliance

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

1. Monitor PSP annual and quarterly meetings to ensure participation of multiple disciplines in integrated discussion continues to occur, that the focus on movement to a more integrated living environment and the individual's preferences drive planning, and that disciplines present the data that inform their impressions of progress, while at the same time guarding against a return to reading reports; use data that is being gathered to make decisions on treatment. The Facility should remind staff of their responsibility to identify the most integrated appropriate environment for individuals.
2. 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.
3. Use the facility process to track completion of assessments and ensure they are done timely, and ensure its process to monitor timeliness of assessments produces accurate and useful information. Develop a process to ensure the assessments include all necessary components.
4. The Structural and Functional Assessment process should be implemented routinely
5. The process of establishing the PFA and using it to guide the development of the PSP needs to be more integrated and robust.
6. 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.

7. Establish a process for ensuring the reliability of data being gathered, including measurement of interrater agreement.

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement (POI) 8/9/11 2. RGSC SOP ICF-MR 400-14 Medical Care revised June 2011 3. PSPs for Individuals #47 and #133 4. PSPs, assessments, CLDPs, and other documents reviewed by members of the Monitoring Team, as identified in other sections of this report 5. Consultation reports for Individuals #1, #5, #19, #47, #54, #63, and #150 6. Template for psychiatry progress notes 7. Annual medical assessment template 8. Integrated Progress Notes (IPN) in Clinical Work Station (CWS) **People Interviewed:** 1. Joint interview: David Moron, M.D., Clinical Director, Lorraine Hinrichs, ICF-MR Director, and Jessica Juarez, RN **Meeting Attended/Observations:** 1. Personal Support Plan (PSP) meeting for Individual #140 2. Risk meetings for Individuals #40 and #80 3. Quarterly PSP Review meeting for Individuals #39 and #74
	Facility Self-Assessment: RGSC reported in the POI that it is not yet in compliance with either provision of this Section. The Facility reported two actions since the last compliance visit. One action was the revision of the Medical Care Policy to include Primary Care Physician (PCP) integration into the PSP process. The other action was the implementation of a Medical Provider Quality Assurance Audit database. Although the Medical Care policy does make explicit the expectation of integration of clinical care and treatment into the PSP and active participation by the PST in planning if clinically indicated, the process of integration was still in early stages. Implementation of the Quality Assurance Audit database is still in process; the Facility reported in the POI that it was still in process of developing a process of audit reviews with the Clinical Director and PCPs, and the audit of charts had not yet begun. The POI did provide a sequence of steps for development and implementation of both the revised Medical Care policy and the quality assurance audit. Both will require additional steps to move from initial implementation to effective integration of clinical services. Furthermore, the entire focus of the POI was on integration of medical care; although medical care is an essential component of clinical services, the action plan must also address other clinical services so that integration encompasses all assessments, supports, and services to be provided to each individual.
	Summary of Monitor's Assessment:

	The Facility was not in compliance with either provision of this Section. Although there had been improvement in integrated discussion during planning meetings, planning remained multidisciplinary. The Medical Care policy had been revised to add expectations for integration of medical care into the PSP but still fell short of full integration. Although there was documentation that Facility clinicians reviewed and agreed with reports and recommendations from non-Facility clinicians, there was at times a lack of follow-up assessment that should have occurred. Furthermore, there was not routine documentation that the PST was notified of results and recommendations and involved in planning when appropriate.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The Facility had continued the more integrated process of PSP planning and review. Dr. Moron reported that physicians participated in both annual and quarterly planning meetings. The Monitoring Team observed physician participation at meetings; however, sign-in sheets for the most recent PSP annual planning meeting at each home did not have evidence of physician attendance. RGSC SOP ICF-MR 400-14 was revised to add expectations for integration of medical care into the PSP. The QMRP is now expected to invite the PCP to all PST/A (Addendum), Quarterly, and Special Staffings, and the PCP is expected to be an active participant. However, the policy still fell short of full integration; for example, the policy requires the PCP (and other healthcare professionals, as appropriate) to review all diagnostic reports but does not address when or how information from these reports should be brought to the attention of the PST as a whole. Nevertheless, planning remained multidisciplinary, That is, several disciplines were involved in planning and reviewing each PSP, and there had been significant improvement in interdisciplinary discussion at these meetings, but most plans and goals continued to be developed discipline by discipline. For example: • Individual #133 was reported as being obese. The PSP noted she is on a 1200 calorie diet, which was not listed as an action plan. The PNM report noted that exercise can be done informally, but the transportation report noted that she would benefit from being transported in a small van, whereas the PST recommended she be transported in a small van or on a golf cart while at RGSC. The PSP did include an action plan for a walking routine, but it also included a service objective for transportation using a small van. There was no indication of planning how to integrate exercise and transportation.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Dr. Moron stated that integration of clinical services takes practice. He reported that he reminds physicians frequently of the need to talk with other clinicians. One area of concentration is the use of pre-treatment sedation; he stated he has been working to ensure discussion of this occurs across disciplines not only before appointments but also at planning and committee meetings; however, as reported in Provision J4, this had not yet resulted in adequate behavioral interventions to reduce need for pre-treatment sedation. Dr. Moron also pointed out that there is more discussion across disciplines, including DCPs, at planning meetings; this was supported by Monitoring Team observations. Dr. Moron also pointed out that Habilitation Services has brought in more adaptive equipment, and that this equipment is reviewed by the PST. Nevertheless, there continued to be lack of integration of habilitation services. For example, 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. Moreover, presence of needed clinicians at PSP planning meetings did not always occur throughout the period since the last compliance visit. Examples included: • Individual #80 has multiple pieces of adaptive equipment but the OT was not available at the PSP annual planning meeting. • Individual #118 has a history of contractures but there was no PT or OT present at the meeting. • For Individual #133, medical supports and services needed included "health concerns of obesity, hypertension, a history of seizures, and a positive PPD" and the individual was at medium risk for cardiac disease, constipation/bowel obstruction, and polypharmacy/side effects, but there was no signature of a physician on the sign-in sheet. There remained examples in which integrated planning did not occur as needed: • PNMPs were not clearly developed with input from all members of the PST or reviewed consistently by the PST. • Individual #11, whose care was discussed in the report for the last compliance visit, still provided an example of lack of fully integrated planning. Treatment planning related to his urinary incontinence focused, at that time, primarily on behavioral intervention with no comprehensive review of a possible medical condition. The PST had met but had not planned in an integrated way. Following the compliance visit, the individual was sent for a urology consultation. A PST meeting to discuss the findings and recommendations from	

#	Provision	Assessment of Status	Compliance
		the urologist did not occur until two months after the urology consultation for the team. The members who attended the meeting included a LVN, PNAIII, Psychology Assistant, and QMRP. The physician did not attend the team meeting. If residual urines remained high after the medication, the urologist recommended the use of a Foley catheter or intermittent catheterization. The team reported there had been no evidence of residuals and catheterization had not been necessary. Review of the record did not find documentation that he had been checked for residual urine. Therefore, it was puzzling how the team could have known there was no problem with residual urines. It was doubtful that the team members present at the meeting were qualified to make medical decisions regarding the urologist recommendations. The physician should have been present and part of the decision making process. Furthermore, although Individual #11 had a bladder and bowel training program, the program was not included as a service plan objective. • Based on a review of 12 individuals' (sample #1, #2, and #3) most recent OT/PT and SLP assessments, zero of 12 individuals (0%) were provided with a comprehensive assessment by the PNM team that focused on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, and positioning during the course of the day and during nutritional intake. PNMPs were not clearly developed with input from all members of the PST or reviewed consistently by the PST. Therefore, although there had been progress in interdisciplinary discussion during planning meetings and in developing expectations for integrated planning, the Facility is not yet in compliance with this provision. To come into compliance, the Facility will need to provide evidence that the discussions lead to integrated planning of goals and interventions, and that the needed clinicians participate in the planning.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	Facility clinicians routinely indicated review of consultation reports from non-Facility clinicians by initialing and dating the consultation forms. The Monitoring Team reviewed consultation reports for Individuals #1, #5, #19, #47, #54, #63, and #150. For all reports, there was documentation that the Facility clinician reviewed and accepted the results and recommendations. For example, PNMPs were revised in response to consultation findings and recommendations. Although review and acceptance occurred, there were examples described in Provision L.1 in which additional follow-up should have occurred but did not. Furthermore, there was not routine documentation that the PST was notified of results and recommendations and involved in planning when appropriate.	Noncompliance

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

1. Revise the Facility policy on Medical Care to provide more clarity on how the medical staff must engage in integrated planning. (Provision G.1)
2. Provide review of PSPs and/or training of PSTs to establish integrated plans and to identify when integrated planning has or has ot occurred. (Provision G.1)

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement (POI) 8/9/11 2. DADS draft policy Minimum and Integrated Clinical Services 1/12/10 3. RGSC SOP ICF-MR 400-14 Medical Care revised June 2011 4. DADS Policy 004 Personal Support Plan Process 7/30/10 5. RGSC SOP MR 600 01 Personal Support Plan Process (Integrated Protections, Services, Treatments, and Supports) last revised 4/11 6. PSPs for Individuals #5, #27, #47, #61, #77, #107, #133, and #140 7. Template for psychiatry progress notes 8. Annual medical assessment template **People Interviewed:** 1. Joint interview: David Moron, M.D., Clinical Director, Lorraine Hinrichs, ICF-MR Director, and Jessica Juarez, RN **Meeting Attended/Observations:** 1. Personal Support Plan (PSP) meeting for Individual #140 2. Quarterly PSP Review meeting for Individuals #39 and #74 3. Risk meetings for Individuals #40 and #80
	Facility Self-Assessment: The Facility reported that it is not yet in compliance with any provision of this Section. The Monitoring Team concurs, except that the Monitoring Team found the Facility to be in compliance with Provision H.2. The Facility did report actions taken or in process to move toward compliance; the Monitoring Team found these reports accurate. The actions described in the POI were simply a set of isolated actions rather than a sequential set of actions designed to move from current status toward compliance. The Facility also listed action steps planned for Provisions H.2, H.4, and H.5, primarily consisting of audits. The current statements of status did not provide data that could be used to assess status; if the actions taken between this compliance visit and the next involve additional auditing, the Monitoring Team would expect that the Facility would use data gathered from these audits as one source of information on status of compliance.
	Summary of Monitor's Assessment: The Facility is in substantial compliance with Provision H.2 and is not in compliance with the remainder of the provisions. Assessments were not consistently provided timely on a routine basis or in response to changes in health

	or behavioral status. Furthermore, assessments were not consistently comprehensive. Interventions were not always implemented or revised timely based on either assessments or clinical indicators. One area of improvement was that the Facility was in process of developing clinical indicators that could be used in a system to monitor health status. The Facility was in substantial compliance with the requirement that all diagnoses be consistent with current standards, and that they clinically fit diagnostic assessments. Although in compliance, the Facility will need to ensure this continues as assessments become more comprehensive.

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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.	Provision of assessments both on a routine basis and in response to changes in health or behavioral status was not consistent across all disciplines. All individuals had received an OT/PT assessment. If newly admitted, this occurred within 30 days of admission (Sample #6). The assessments submitted were completed by both OT and PT. However, as reported in Provision P.1, review of individuals with changes in status did not provide evidence of assessment or review as indicated by a change in the individual's status or as dictated by monitoring results. Furthermore, as reported in Provision O.2, individuals did not receive comprehensive assessments on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake. Finally, as reported in Provision P.1, although assessments exist for all individuals, they were not comprehensive, as the assessment lacked analysis of findings that were based on the data, comparative analysis to previous assessments, and methods to identify and develop the acquisition of skills. However, routine nursing assessments were not consistently completed timely, as reported in Provision M.2. There were improvements in the quality of Comprehensive Nursing Assessments but concerns still remained. Although annual medical assessments were completed, there was a lack of follow-up assessment for some chronic and acute or emergent medical conditions, as reported in Provision L.1. Although the Facility had contracted with two consultants to complete psychological assessments, there had not yet been an increase in the percentage of individuals who had received a psychological assessment or update in the last year.	Noncompliance

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		The Monitoring Team did note significant improvement in updating Axis 1 diagnoses based on psychiatric evaluations. The Clinical Director had established a template for psychiatry progress notes and one for annual medical assessments. Both should help ensure all needed components are present. The Facility had not established an overall improvement plan to address completion of evaluations. The Facility had, in June 2011, begun to audit presence of required assessments 10 days prior to PSP annual planning meetings. This and the contracts for psychological assessments were positive steps. Still, it would be wise for the Facility to establish a comprehensive plan to ensure assessments are completed on both a routine basis and in response to changes in health and behavioral status.	
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.	The Monitoring Team noted great improvement with updating Axis I Diagnosis. The Monitoring Team was informed by the Clinical Director that all diagnoses had been updated, and those reviewed by the Monitoring Team demonstrated updated and accurate description of Axis I and II diagnoses. The Facility and professional staff had worked extensively to accomplish this. All diagnoses reviewed by the Monitoring Team were consistent with the current version of the DSM and ICD. Although in compliance, the Facility will need to ensure this continues as assessments become more comprehensive.	Substantial Compliance
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.	Although many treatments and interventions were provided timely, there were many examples in which timely implementation of interventions did not occur. One reason was the lack of assessment when changes in health or behavioral status occurred, or when clinical indicators did not show progress. As identified in Provision H.1 and other Sections of this report, there were still gaps in completion of both routine assessments and assessments in response to changes in status. For example, as documented in Provision K.4 and noted in Provision H.4, data on behaviors targeted for reduction showed no change or increases for extended times before changes in intervention were made. As documented in the case of Individual #94 in Provision L.1, and in the cases of Individuals #15 and #93 in Provision P.1, individuals experienced numerous falls over extended periods without thorough assessment.	Noncompliance

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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.	Facility clinicians indicated they used standard clinical indicators to evaluate status of individuals. Per report of the Clinical Director, the Facility had begun a process of audits of records by a physician from the outpatient clinic operated by RGSC. One purpose of these audits is to identify clinical indicators that could be collected and trended. Facility PCPs were in the process of identifying useful clinical indicators for health care. Some data had been collected, such as data on pneumonia, but trending had not yet been done. The Facility had identified other areas for identification of clinical indicators but had not yet determined useful indicators to track; one such area was dental care—both oral hygiene and the use of pre-treatment sedation for dental care. This was a good beginning and should be continued. In addition, the identification of clinical indicators should be expanded to all areas of supports and services, including habilitation and behavioral services. For example, although PNMPs are reviewed at the PSP, there was not a system fully in place that clearly monitored the effectiveness of the plan by tracking clinical indicators for all individuals who are determined to be at an increased risk, such as the occurrence or absence of triggers (signs and symptoms associated with physical and nutritional decline that require staff response). A substantial issue noted in the records involved the failure to use available data in determining whether an individual was displaying a reduction in target behavior following the introduction of an intervention. In several of the reviewed documents, data did not reflect improvement following a change in treatment. In other circumstances, individuals were noted to display worsening behavior following a change in treatment, but data did not reflect an effort to stop or revise the ineffective treatment method. • For Individual #8, a new PBSP was implemented in September 2010. By March 2011, reported monthly incidents of aggression had increased from zero to nine. The PBSP was not revised until May 2011. • For Individual #36, target behaviors remain at a high level for one year without a review of the need for revision to the intervention. In other cases, some data that could be used for clinical indicators was available but it was unclear whether additional useful information could be found. • Individual #5 had active problems for Prader-Willi, Type II Diabetes, and Obesity with a BMI of 35. His Annual and Quarterly Comprehensive Nursing Assessments for 2/16/11, 5/16/11, and 8/14/11 indicated his was 57 pounds or 64% above the upper limit of his desired weight limit (weight being a clinical indicator). He was receiving a regular 1500 calorie, ADA, low fat diet. The Weight Management Summary sections did not include a summary describing compliance with the diet (possible a useful clinical indicator), although he had a HMP for imbalanced nutrition	Noncompliance

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		related to overweight. Neither did the Section XI nursing summaries describe his progress toward weight management goals and objectives or the effectiveness of the plan of care. The Facility should continue to identify useful clinical indicators of medical conditions and should develop a comprehensive plan to identify and track clinical indicators for a broad range of treatments and interventions. In addition, for compliance to be achieved, the Facility will need to demonstrate that clinical indicators are used in making decisions at both an individual and systemic level.	
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.	As reported in Provision H.4, the Facility had begun to identify clinical indicators that could be used in a system to monitor health status. As clinical indicators are developed, indicators that are most useful for such monitoring should be identified and trended, and data gathered should be evaluated. The Facility had implemented a new risk assessment process and was continuing to refine it. It was still in early stages of implementation and did not yet fully result in accurate identification of risk nor identify appropriate frequency of monitoring or how risk ratings could be used to monitor health status of individuals. Issues of risk and health monitoring for specific disciplines or areas of concern also need to be addressed. For example, regarding physical and nutritional management, 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. A policy/protocol that addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted did not exist at RGSC. A policy or process was not fully developed that included: • Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, • Identification of monitors and their roles and responsibilities, • 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 • 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	The Facility did not have or provide clear guidance to clinicians and PSTs on when treatments and interventions should be modified in response to clinical indicators. As indicated in numerous examples in Sections K, L, M, and P, treatments and interventions	Noncompliance

#	Provision	Assessment of Status	Compliance
	years, treatments and interventions shall be modified in response to clinical indicators.	continued without modification even as conditions appeared to worsen or did not show progress. The Facility should establish clear expectations and, to the extent possible, guidelines and timelines for clinicians and PSTs, that treatments and interventions will be modified when clinical indicators do not show progress.	
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 was revised to add expectations for integration of medical care into the PSP. However, the policy still fell short of full integration of medical care. Both DADS and RGSC PSP policies address integration of clinical services into the PSP process; however, as reported in Section F, such integration had not yet been fully put into place. Furthermore, policies for other clinical disciplines need to be revised, and full implementation of integration needs to occur.	Noncompliance

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

1. Establish a comprehensive plan to improve completion of assessments, both on a routine basis and in response to changes in health and behavioral status. (Provision H.1)
2. Develop a comprehensive plan to identify and track clinical indicators for a broad range of treatments and interventions. (Provision H.4)
3. Establish clear expectations and, to the extent possible, guidelines and timelines for clinicians and PSTs, that treatments and interventions will be modified when clinical indicators do not show progress. (Provision H.6)

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement (POI) 8/9/11 2. RGSC SOP MR 400-02 At Risk Individuals revised 2/11 3. DADS At Risk Policy 6.2 updated 2/18/11 4. Records for Individuals #1, #5, #11, #15, #19, #27, #35, #39, #40, #47, #54, #60, #62, #63, #93, #108, #113, #126, #134 and #150 P**eople Interviewed:** 1. Lorraine Hinrichs, ICF-MR Program Director 2. Mary Ramos, Quality Management Director 3. Rosie Sanchez, QE Coordinator 4. Alondra Machado, Data Analyst 5. Janie Villa, QMRP Manager 6. Megan Gianotti, Psychology Manager **Meeting Attended/Observations:** 1. Incident Management Review Team (IMRT) 8/22/11 2. Settlement Agreement Performance Improvement Council (SA-PIC) 8/24/11 3. Personal Support Plan (PSP) meeting for Individual #140 4. Risk meetings for Individuals #40 and #74
	Facility Self-Assessment: The Facility's self-assessment reported the RGSC was not in substantial compliance with any provision or component of this section of the Settlement Agreement (SA). The Monitoring Team was unable to identify any specific self-assessment processes or procedures used by the RGSC to make this determination of noncompliance. The Facility reported it had initiated and provided training on the revised risk assessment procedure and that procedures were in place to follow the revised State policy. The Monitoring Team's review did not find this to be the case and substantiated noncompliance with this section of the SA.
	Summary of Monitor's Assessment: The RGSC processes to demonstrate compliance with this section of the SA were insufficiently organized to enable a comprehensive review. Risk assessment documents frequently could not be located and/or were not integrated into the PSP. The Monitoring Team noted many instances where the risk level assigned to an individual was not accurate. The statewide risk assessment procedure, with improved guidelines for rating risk, had been initiated, but with little success. Risk assessments were often not conducted within five working days of risk identification or a change in circumstances. Additionally, professional staff implementation of the Risk Assessment policy was inconsistent, indicating a need for additional training and professional oversight. Interdisciplinary discussion required to properly assess risk and develop risk mitigation strategies was not apparent to the Monitoring Team. For example, in most records sampled, the Monitoring Team determined

	that assessments were not sufficiently comprehensive to enable interdisciplinary discussion. The lack of work flow organization, and professional oversight of the risk assessment process, prevented the RGSC from identifying risk timely and appropriately, which in turn prevented the development of timely and appropriate risk mitigation plans.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The RGSC reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. RGSC revised its policy for at risk individuals in February 2011. These revisions aligned the RGSC policy with the DADS policy. RGSC was implementing the new statewide risk assessment procedure, with improved guidelines for rating risk, but with limited success. Very few individuals were rated as high risk in any risk criterion. This was because, in most cases, risk level determinations were being made based on events that had already occurred (i.e. an individual had a choking incident), or, on a medical diagnosis related to a specific disease process. The Monitoring Team found no evidence that clinicians at RGSC were reviewing potential for risk in sufficient detail and depth to accurately assign risk levels and develop appropriate risk mitigation strategies and action plans. The Monitoring Team observed many individuals during the review who should have been rated at a higher risk level than the current rating. The Monitoring Team observed the one PSP meeting that was held during the week of the review. There was very limited discussion related to risk. This individual wanted to move to a group home so much of the meeting discussion focused on the potential move. This discussion indirectly focused on some elements of risk, such as the need for the new home being accessible. To the degree discussion focused on risk, it was not directed at the specific criterion contained in the risk policy and did not include review of clinical data that would be necessary to conduct a risk review. Staff present at the PSP was the actual staff who worked with the individual. The individual and her father/guardian were present at the meeting. Both participated in the discussion. The LAR and regular staff could provide information about risks due to their regular involvement with her. The PST did not provide adequate justification of designated risk levels at the PSP meeting observed by the Monitoring Team, so there was no documentation to show appropriateness of the ratings of risk level. The Monitoring Team requested that two PSTs participated in special meetings to go through their reviews of risk for an individual. One meeting was interrupted because of a	Noncompliance

#	Provision	Assessment of Status	Compliance
		medical emergency. As a result there was limited opportunity for the Monitoring Team to provide technical assistance to the PST.	
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 reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The Monitoring Team reviewed 12 PSPs and related documents to determine if appropriate risk assessment activity had taken place and was documented. These included Individuals #1, #5, #11, #19, #27, #39, #40, #47, #63, #108, #126 and #150. There was only one instance (8%), Individual #5, of clear documentation that the PST started the assessment process as soon as possible but within five working days of the individual being identified as at risk. With other individuals, no risk assessment documentation could be located, for example Individuals #1, #19, and #150, or an assessment process started but not within five days, for example Individuals #40, #108, and #126. The records of these 12 individuals were reviewed to determine if changes in circumstance should have resulted in changes to an at-risk assessment, rating, and plan. There were examples of risk events or changes in status. There was documentation that the PST started the assessment process as soon as possible but within five working days of the individual changes in an at-risk condition for only one (8%) individual, Individual #126. Records that did not contain documentation of this requirement included: #1, #5, #11, #19, #27, #39, #40, #47, #63, #108, and #150. Based on a review of records of five individuals (Individuals #5, #11, #40, #108, and #126) for whom assessments had been completed to address the individuals' at risk conditions, one (20%) included an adequate nursing assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included Individuals #5, #11, #108, and #126. The following provides an example of an assessment that was not comprehensive: The PSP on 4/26/11 rated Individual #11's risk for Urinary Tract Infections (UTIs) low in spite of a long standing history and diagnosis of urinary retention. Although he did not have a history of UTIs, the fact that chronic urinary retention has the potential to cause UTIs, bladder damage due to prolonged overstretching of the muscles, and chronic kidney damage, merits consideration for a higher level of risk. There was no documentation to validate such consideration. The PST should have increased his level of risk to at least medium, if not high. Other examples of deficiencies in risk screening and assessment processes include:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• None of four (0%) individuals (#19, #47, #54, and #134) who were diagnosed with a Physical and Nutritional Management (PNM) issue was provided with a risk screening in response to a change in status. • Individuals #15, #35, and #93 experienced multiple falls but there was no evidence that the team met to review the risk status. • Individuals who were diagnosed with a PNM issue were not assessed by the PNMT or PST. For example: o Individual #54 was diagnosed with aspiration pneumonia on 4/21/11 but there was no evidence of reassessment upon return or discussion of the event by the PST. There was discussion by the PNMT but this did not occur until 5/5/11. Additionally, a MBSS was provided on 5/5/11 which indicated silent aspiration and the need to transition to nectar liquids. This resulted in the individual receiving unsafe liquids for 13 days. o Individual #19 was diagnosed with aspiration pneumonia on 7/25/11 but there was no evidence of reassessment upon return or discussion of the event by the PST. There was also no discussion by the PNMT at the 8/3/11 meeting.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	The RSSLC reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The Monitoring Team reviewed 12 PSPs and related documents to determine if appropriate risk assessment activity had taken place and was documented. These included Individuals #1, #5, #11, #19, #27, #39, #40, #47, #63, #108, #126 and #150. There was documentation that the Facility: • Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate in two (16%) cases. Records that did not contain documentation of this included Individuals #1, #5, #11, #19, #27, #39, #47, #63, #108, and #150. • Implemented a plan that met the needs identified by the PST assessment in two (16%) cases. Records that did not contain documentation of this included Individuals #1, #5, #11, #19, #27, #39, #63, #108, #126 and #150. • Included preventative interventions in the plan to minimize the condition of risk in two (16%) cases. Records that did not contain documentation of this included Individuals #1, #5, #11, #19, #27, #39, #63, #108, #126 and #150. • Of two cases in which the risk to the individual warranted, the Facility took immediate action in two (100%) cases. • Integrated the plans into the PSPs in two (16%) cases. Records that did not contain documentation of this included Individuals #1, #5, #11, #19, #27, #39, #63, #108, #126 and #150.	Noncompliance

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		• In one (8%), the risk plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. Records that did not contain documentation of this included Individuals #1, #5, #11, #19, #27, #39,#47, #63, #108, #126 and #150. • In two (16%), appropriate functional and measurable objectives were incorporated into the PSP to allow the team to measure the efficacy of the plan. Records that did not contain documentation of this included Individuals #1, #5, #11, #19, #27, #39, #63, #108, #126 and #150. • Included the clinical indicators to be monitored and the frequency of monitoring in two (16%) cases. Records that did not contain documentation of this included Individuals #1, #5, #11, #19, #27, #39, #63, #108, #126 and #150. The Monitoring Team was able to identify only one risk management/mitigation plan that was comprehensive and individualized to the extent that if followed risk would be effectively managed or mitigated. This was for Individual #40. In many cases risk assessments and mitigation plans could not be located (Individuals #1, #5, #19, #39, #63, and #150). The Monitoring Team reviewed the circumstances associated with Individual #11 because of concerns identified during the last compliance review. On 3/3/11 Individual #11 was sent to the Urologist to evaluate urinary retention. He was diagnosed with urinary retention secondary to outlet obstruction and medication prescribed to relieve bladder distention. He was continuing to be followed by the Urologist. A Urinary Incontinence HMP that included a bowel and bladder training program was initiated on 3/4/11, and reviewed on 4/17/11 and 7/23/11. The bladder and bowel training plan called for the direct care professionals to take Individual #11 to the bathroom every two hours for toileting. Review of the Integrated Progress Notes over the past six months failed to document effectiveness of these plans or report episodes of urinary incontinence. The PSP on 4/26/11 rated Individual #11's risk for Urinary Tract Infections (UTIs) low in spite of a long-standing history and diagnosis of urinary retention. Although he did not have a history of UTIs, the fact that chronic urinary retention has the potential to cause UTIs, bladder damage due to prolonged overstretching of the muscles, and chronic kidney damage. The PST should have increased his level of risk to at least medium, if not high. On 5/10/11 the PSPA met to discuss Individual #11's urology consult of 3/3/11. It was of concern that it took the PST two months after the urology consultation for the team to meet and discuss the findings and recommendations from the urologist. The members	

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		who attended the meeting included an LVN, PNAIII, Psych Assistant, and QMRP. The physician did not attend the team meeting. If residual urines remained high after the medication, the urologist recommended the use of a Foley catheter or intermittent catheterization. The team reported there had been no evidence of residuals and catheterization had not been necessary. Review of the record did not find documentation that he had been checked for residual urine. Therefore, it was puzzling how the team could have known there was no problem with residual urines Although Individual #11 had a bladder and bowel training program, the program was not included as a service plan objective. Planning and revision of the services and supports for this individual, including medications, continued. Individual #11's problem with urinary incontinence and retention was identified and reported at the last review. Nevertheless, actions to reduce risk were not timely, and integrated planning to reduce risk was not evident consistently. Additional observations involving Physical and Nutritional Management and related to this component of the SA include: • All persons identified as being at risk (requiring PNM supports) were provided with a Physical and Nutritional Management Plan (PNMP); however, the plans were not comprehensive (please refer to Section O). • PNMPs were not reviewed by the PST and were not consistently updated in a timely manner by Habilitation Therapies as indicated by a change in the person's status. In three of eight records reviewed (37%), PNMPs were revised in a timely manner as indicated by a change in the individual's status.	

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

1. The Facility should assure all PSTs are provided with training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the new PSP process. QMRPs/Team leaders should be provided with competency based training and job coaching on implementation of the At Risk policy and its incorporation into the PSP process.
2. Ensure that appropriate and timely assessment and revision of the PSP is done for any individual whose level of risk is revised as the At-Risk Individuals policy is implemented.

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement (POI) 8/9/11 2. Staffing plan for psychiatry services, memo issued by Dr. Moron, dated September 7, 2011 3. RGSC Standard Operating Procedure, ICF-MR 400-13, dated December 3, 2010 4. RGSC Standard Operating Procedure HIM 400-16, entitled Completion of Psychiatric Evaluation/Mental Status At Admission/AIMS Assessments, dated March 1, 1996 5. Rio Grande State Center Psychiatric Evaluations/Assessments form, revised August 24, 2011 6. Psychiatric evaluations for Individuals #140, #139, #84, #3, #66, #2, #54, #134, and #40 7. Individual Supports for Medical/Dental Appointments form for Individuals #12, #72, #108, #113, #91, and #35 8. Current list of all individuals who receive pre-treatment sedation for dental and medical procedures and evaluations 9. Rio Grande State Center, Medical Staff Bylaws, revision 10/13/10, Exhibit A, Psychiatric Evaluations/Assessments. 10. Completed Reiss Screens for Individuals: #91, #47, #88, #8, #108, #118, #74, #98, #39, and #113 11. Written Plan for Professional Services dated March 2011 12. ICF-MR Services Manual; Personal Support Plan Process, dated October 2010 13. Polypharmacy Workgroup Committee meeting minutes dated August 8, 2011 and August 12, 2011. 14. Consent to Treatment with Psychoactive Medication Forms for Individuals #76, #15, and #61 15. Physician orders, psychiatric evaluations and WORx summary for Individuals #94, #150, #84, #4, 101, #12, #66, #67, #96, and #3 16. Minutes from the March, 2011 P&T Sub-Committee meeting **People Interviewed:** 1. David Moron, MD – Clinical Director and Treating Psychiatrist 2. Dan Weathers, MD - Psychiatrist **Meeting Attended/Observations:** 1. None
	Facility Self-Assessment: The Facility's POI, dated June 13, 2011, was reviewed in detail by the Monitoring Team. The Monitoring Team identified many of the actions reported by the Facility; however, the Monitoring Team finds the POI to be a checklist of activities completed, and it does not enable the Monitoring Team to have an understanding of the Facility's overall plan for future compliance. The Facility reported compliance with Provision J.1, of the Settlement Agreement, and the Monitoring Team concurs that the Facility does, in fact, have a sufficient number of qualified psychiatrists to provide psychiatric services at the Facility. Although the Facility assessed itself non-compliant with Provisions J.5, and J.7, of the Settlement

	Agreement, the Monitoring Team concluded that the Facility was in substantial compliance. The Monitoring Team concurred with the Facility's self assessment of being not in compliance with Provisions J.2, J.3, J.4, J.6, J.7, and J.8, of the Settlement Agreement. Further details of the Monitoring Teams review, comments, and recommendations can be found further in this report.
	Summary of Monitor's Assessment: Provision J1: This provision was determined to be in substantial compliance. The Monitoring Team strongly encourages the Facility to maintain or enhance its current staffing ratio for psychiatry. Provision J2: This provision was determined to be not in compliance because data analysis was not considered prior to prescribing psychotropic medications, and not considered when developing a psychiatric case formulation. A process must be developed that ensures that psychiatrists incorporate behavior analysis into their case formulation, prior to initiating psychotropic medication therapy. The process must be efficient and must not result in significant treatment delay. Provision J3: Following a review of physician orders for psychotropic medications, psychiatric evaluations, and a summary of the WORx database, for Individuals #94, #150, #84, #4, 101, #12, #66, #67, #96, and #3, and P&T Committee meeting minutes that addressed STAT medications, the Monitoring Team determined that the Facility is in substantial compliance for this provision because psychotropic medications are not used for staff convenience or as a means of punishment. Provision J4: This provision was determined to be not in compliance because of the Facility's failure to include a meaningful review of the need, and use of pre-treatment sedation into the PSP process. The Facility must enhance its review of all pre-treatment sedation use at the Facility. Provision J5: Following review of the Facility's staffing plan for psychiatric services, the Monitoring Team determined that the Facility has adequate quantity and quality of professional staff for psychiatry; hence, the Facility is in substantial compliance with the provision. Provision J6: Because the Facility did not include a review of systems, incorporate behavioral data into the case formulation, and perform more than regularly scheduled DISCUS, when necessary, or comment on abnormal DISCUS results, the Monitoring Team determined that the Facility is not in compliance with the Provision. J7: Because the Facility has a process to screen all new admissions with the Reiss Screen, and because all Individuals at the Facility have been screened by the Reiss, and because the quality of the Reiss screen is evident, the Monitoring Teams review, the Monitoring Team determined that the Facility is in substantial compliance with provision. Provision J8: The Monitoring Team's review of Psychiatric Assessments identified that the Facility does not consider behavior data and behavior programs when conducting psychiatric assessments. For this reason

	the Monitoring Team concluded that the Facility remains out of compliance with Provision. The Facility must ensure that psychiatry better incorporate behavior data and consider behavior programs, when conducting psychiatric assessments. Provision J9: Because the psychiatrist does not participate in the PST process, nor contribute to the development of positive behavior support plans, the Facility remains non-compliant with the provision. Provision J10: Because the psychiatrist, primary care physician, and nurse do not regularly participate at PST meetings to determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medications, the Monitoring Team determined that the Facility remains noncompliant with Provision. The Facility must ensure a robust and meaningful process is in place that ensures active participation on the part of its clinical professionals in the team process. Provision J11: The Facility had yet to complete a comprehensive review of polypharmacy and provided only limited review of those discussed at the polypharmacy meeting. The Facility did not have a comprehensive policy or operating procedures for the polypharmacy committee. The Facility did not consider the combination of a first generation and a second generation antipsychotic as polypharmacy. , The Polypharmacy Committee offered only minimal recommendations and action plans. Therefore, the Monitoring Team concluded that the Facility is not in compliance with Provision J11. The polypharmacy committee must perform a comprehensive review of polypharmacy by reviewing longitudinal data, efficacy of behavior programs and medications, risk and benefits of treatments versus alternative or no treatment, and must offer meaningful recommendations with follow-up. Provision J12: The Facility is not in compliance because it does not appropriately complete side effect assessments, provide more frequent side effect monitoring when clinically appropriate, and ensure that there is an effective system in place to respond to side effects of psychotropic medications. Provision J13: Psychiatrists at the Facility were not actively involved in the PSP process when developing treatment plans for the use of psychotropic medications, as delineated by the Settlement Agreement; hence, the Facility is not in compliance with the provision. An efficient, and efficacious process must be developed that ensures the psychiatrists' collaboration with the psychologist and PST, when developing treatment plans for the use of psychotropic medications. Provision J14: The Facility is not in compliance with provision J14 because it does not ensure that the consent process clearly and effectively delineates the indication; dose, route and frequency of the medication; who is prescribing and monitoring the medication; terms of the consent process, including an expiration date; alternative treatments considered, including no treatment and behavioral approaches; target symptoms/behaviors that require monitoring to assess efficacy; well documented and explained serious side effects of the medication, especially TD, NMS, and agranulocytosis for antipsychotics; and off-label use of treatments that should be considered as a component of the consent process and/or well documented in the clinical record.

	Provision J15: Because the Facility does not have a formal process that ensure collaboration among the psychiatrist and neurologist when addressing medications used for comorbid neurological and psychiatric conditions, within the context of the PST process, the Facility was determined to be not in compliance with the provision. A process must be developed and implemented that ensure an efficient and efficacious process enabling communication of clinical issues specific to the use of psychotropic medications when administered for both psychiatric and neurological conditions. The Facility should explore efficient mechanisms to convey such information.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	To determine compliance, the Monitoring Team met with the Clinical Director, Dr. Moron, who also serves as a staff psychiatrist, and reviewed the Facility's staffing plan for psychiatric services. The Facility had a full time equivalent Locum Tenens psychiatrist who provides psychiatric services to the individuals residing at the Facility. Dr. Moron provided cross coverage for the Locum Tenens position whenever necessary. Dr. Moron was also available for unscheduled issues, and psychiatric emergencies. In addition, the Facility maintained a robust on-call system that enables individuals to be triaged after hours, and staffed whenever the primary psychiatrist is unavailable. The Facility was vigorously attempting to hire a full time Psychiatrist to assume the locum tenens position. The Monitoring Team determined that the Facility remains 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 Monitoring Team discussed compliance with the Clinical Director, who serves as Staff Psychiatrist, and Staff Psychiatrist Dr. Dan Weathers. The Clinical Director, Dr. Moron, informed the Monitoring Team that all individuals at the Facility had been reviewed and diagnoses updated. The Monitoring Team also reviewed nine completed Psychiatric Evaluations (Individuals #140, #139, #84, #3, #66, #27, #54, #134, and #40). Standard Operating Procedure HIM 400-16, entitled Completion of Psychiatric Evaluation/Mental Status At Admission/AIMS Assessments, dated March 1, 1996, and Rio Grande State Center Psychiatric Evaluations/Assessments Form, revised August 24, 2011 were reviewed. The Monitoring Team noted great improvement with updating Axis I Diagnosis. The Monitoring Team was informed by the Clinical Director that all diagnoses had been updated, and those reviewed by the Monitoring Team (Individuals #140, #139, #84, #3, #66, #27,#54, #134, and #40) demonstrated updated and accurate description of Axis I and II diagnoses. The Facility and professional staff had worked extensively to accomplish this. The Facility continued to work diligently towards compliance with Provision J2. The Facility indicated it will begin to ensure that data analysis and behavioral plans are	Noncompliance

#	Provision	Assessment of Status	Compliance
		considered when formulating a case and prior to prescribing psychotropic medications. None of the psychiatric assessments reviewed by the Monitoring Team had comments regarding behavior assessments or data analysis. Because data analysis was not considered prior to prescribing psychotropic medications and not considered when developing a case formulation, the Monitoring Team determined that the Facility is non-compliant with Provision J.2, of the Settlement Agreement.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	Following review of physician orders for psychotropic medications, psychiatric evaluations, and a summary of the WORx database for Individuals #94, #150, #84, #4, 101, #12, #66, #67, #96, and #3, and P&T Committee meeting minutes that addressed STAT medications, the Monitoring Team noted that 100% of the sample reviewed indicated that medications were prescribed for well defined psychiatric conditions that were justified by the psychiatrist at the time of prescribing the medication. Each case demonstrated a clinical rationale that supported the medication being prescribed for a well-defined DSM diagnosis. The Monitoring Team concluded that the Facility does not prescribe psychotropic medication for the convenience of staff or as punishment and determined the Facility to be in substantial compliance.	Substantial Compliance
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	The Clinical Director informed the Monitoring Team that documentation of pre-treatment sedation and related behavioral approaches was recently enhanced. The Facility's practice was to document review of pre-treatment sedation on the Individual Supports for Medical/Dental Appointments form, which is a component of the Personal Support Plan (PSP). To assess if the Facility delineated treatments or strategies to minimize or eliminate the need for pre-treatment sedation in the Personal Support Plan, the Monitoring Team requested the support plans of nine individuals who received pre-treatment sedation. The Monitoring Team received copies of the Individual Supports for Medical/Dental Appointments, for six Individuals #12, #72, #108, #113, #91, and #35. The Monitoring Team was informed that three of the Individuals requested for review, Individuals #36, #139, #145, did not have documents for review. In general, with the exception of one document for Individual #108, for a 3/24/11 appointment, the PST did not comment on behavioral desensitization programs when reviewing pre-treatment sedation. The following review of Individual #108 is an example of what information is discussed regarding pre-treatment sedation, for multiple appointments. Individual #108:	Noncompliance

#	Provision	Assessment of Status	Compliance
		3/24/11: Follow-up staffing for a 3/25/11 dental appointment. Pending dental appointment was reviewed by the PST and documented and stated "continue with dental rehearsals and dental desensitization program" but did not discuss details of the program and its efficacy or lack of efficacy. 5/6/11: The support plan did not comment on pre-treatment sedation; no behavioral program was delineated; there was no follow-up staffing completed, as required by their process. 5/23/11: The support plan commented on the need for pre-treatment sedation, and that the individual attends dental rehearsals; however, there were no specifics outlining a behavioral program for desensitization. 5/24/11: Commented that "anxiety level increases when out of RGSC", and that this was the second attempt to obtain a medical procedure without pre-treatment sedation. The Team recommended pre-treatment sedation for the procedure. There was no comment about specific behavioral intervention. 5/25/11: Follow-up staffing for the 5/24/11 pre-treatment sedation was conducted on 5/25/11. It was documented that "is unknown if recommendations were followed. 2 staff were taken to appt with (the individual)." There was no discussion about pre-treatment sedation and/or a behavioral plan to address desensitization. 5/26/11: The Plan noted that the Individual was not provided pre-treatment sedation for the 5/24/11 appointment and that she would be sent for the procedure on this date for the procedure under general anesthesia. There was no comment on behavioral intervention attempts. There was no post-procedural follow-up, as required by their process. 6/8/11: The Monitoring Team was provided a total of four Individual Supports for Medical/Dental Appointment forms, for the same Pre-Appointment Staffing Meeting (same date and time). Each document had different entries. None commented on a behavioral plan. Based on the information provided, the Monitoring Team concluded that the Facility is not in compliance with Provision J4, of the Settlement Agreement. By failing to include discussion on desensitization, the Facility did not comprehensively address the issue of pre-treatment sedation, within the context of the Personal Support Plan.	
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	Following review of the Facility's staffing plan for psychiatric services, the Monitoring Team determined that the Facility had adequate quantity and quality of professional staff for psychiatry; hence, the Facility is in substantial compliance with the provision.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	necessary for implementation of this section of the Agreement.		
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 Monitoring Team reviewed the Facility's current Medical Staff Bylaws, 10/13/10, Exhibit A, which provides instruction on completing a psychiatric evaluation. In addition, the Monitoring Team reviewed Psychiatric Evaluations for Individuals #140, #139, #84, #3, #66, #2, #54, #134, and #40. Both the Medical Staff Bylaws and completed evaluations on all nine individuals did not address the following: Identification of positive medical findings through review of medical systems and of reports of physical examination including DISCUS results, and incorporation of behavioral data analysis are not components of the Facility's psychiatric assessment process. Such components are required by a psychiatrist when conducting a comprehensive psychiatric assessment. Appendix B requires that physical examination be reported; this is consistent with standard of care practice that requires the psychiatrist to perform a review of systems when performing a comprehensive psychiatric assessment. Appendix B requires a report of "Pertinent Positive and Negatives"; review of systems requires describing findings that are not usually seen as part of a psychiatric illness. This can be more challenging and important because many individuals with intellectual disabilities are unable to communicate their symptoms of illness; hence, the review of systems may need to be obtained by a combination of assessing the individual, questioning staff, reviewing the physician's current report, and reviewing the MOSES. The Medical Staff Bylaws and Medical Department procedures should clarify what is required as part of the psychiatric assessment. When evaluating individuals with Intellectual Disabilities, it is essential that behavioral data be included within the context of a psychiatric evaluation. There was no evidence that behavioral data was incorporated into case formulations. There was no evidence that the Psychiatrist incorporated results of a DISCUS assessment in the evaluation. It is generally accepted that a DISCUS, or similar evaluation, be reviewed by the psychiatrist, at the time of the psychiatric evaluation. Because the Facility did not include a review of systems, incorporate behavioral data into the case formulation, or comment in the evaluation on DISCUS results, the Monitoring Team determined that the Facility is not in compliance with Provision J.6, of the Settlement Agreement.	Noncompliance
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive	During discussion with the Clinical Director, the Monitoring Team reviewed the Facility's use of the Reiss Screen. The Clinical Director informed the Monitoring Team that all individuals admitted to the Facility would receive a Reiss Screen. The Monitoring Team reviewed the Facility's Written Plan for Professional Services dated March 2011, which	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	indicates that a Reiss Screen will be provided to all Individuals who are admitted to the Facility. The Facility went beyond screening new admissions, and had screened all individuals who reside at the Facility. The Monitoring Team requested the last 10 consecutive Reiss Screening assessments completed by the Facility (Individuals #91, #47, #88, #8, #108, #118, #74, #98, #39, and #113). The Monitoring Team noted that all assessments were completed appropriately. Because the Facility had a process to screen all new admissions with the Reiss Screen, and because all Individuals at the Facility had been screened by the Reiss, and because of the quality of Reiss Screening, as evident by the Monitoring Team's review, the Monitoring Team determined that the Facility is in substantial compliance with provision J.7, of the Settlement Agreement.	
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.	While assessing compliance for Provision J.8, the Monitoring Team reviewed psychiatric assessments for Individuals #140, #139, #84, #3, #66, #2, #54, #134, and #40. The Monitoring Team also discussed compliance issues with the Clinical Director. The Clinical Director informed the Monitoring Team that psychiatrists have yet to fully implement a process to integrate behavior data while conducting a psychiatric assessment or prior to prescribing psychotropic medications. Standard of care practice in developmental disability psychiatry is to consider behavior data, and behavior interventions when developing a treatment plan and/or prescribing psychotropic medications. The Monitoring Team's review of Psychiatric Assessments identified that the Facility did not consider behavior data and behavior programs when conducting psychiatric assessments. For this reason the Monitoring Team concluded that the Facility remains out-of-compliance with Provision J.8, of the Settlement Agreement.	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,	During discussions with the Clinical Director, the Monitoring Team was informed that when developing a least intrusive personal support plan, the Psychiatrist did not participate at the PST meeting nor contribute to development of positive behavior support plans for individuals receiving psychiatric care. Review of psychiatric assessments for Individuals #140, #139, #84, #3, #66, #2, #54, #134, and #40 indicates that behavior data analysis, and behavior intervention plans were not considered by the	Noncompliance

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	the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	Psychiatrist. Based on the information presented to the Monitoring Team by the Clinical Director, and review of psychiatric assessments, the Monitoring Team concluded that the Facility remains noncompliant with Provision J.9, 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.	The Monitoring Team was informed by the Clinical Director that psychiatrists and primary care physicians were not consistently participating at PST meetings to determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medications. Review of personal support plans at the Facility substantiated the Clinical Director's statement. The Facility's plan of improvement indicated that the "new PSP process" (ICF-MR Services Manual; Personal Support Plan Process, dated October 2010), ensures that a nurse, primary care physician, and psychiatrist participate at PST meetings to determine whether the harmful effects of the Individual's mental illness outweigh the possible harmful effects of psychotropic medications. Following review of the ICF-MR Services Manual; Personal Support Plan Process, the Monitoring Team was unable to identify whether a nurse, primary care physician, and psychiatrist participated at PST meetings to determine whether the harmful effects of the Individual's mental illness outweigh the possible harmful effects of psychotropic medications. Because a psychiatrist, primary care physician and nurse did not regularly participate at PST meetings to determine whether the harmful effects of the Individual's mental illness outweigh the possible harmful effects of psychotropic medications, the Monitoring Team determined that the Facility remains non-compliant with Provision J.10, of the Settlement Agreement.	Noncompliance

#	Provision	Assessment of Status	Compliance
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	Per discussion with the Clinical Director, the Facility had implemented a polypharmacy committee that will meet monthly to review polypharmacy issues. The committee was launched in July, 2011, and will provide regular and comprehensive review of polypharmacy. The Monitoring Team requested a list of all individuals so far reviewed for polypharmacy, and minutes from previous polypharmacy committee meetings. Minutes from the 8/8/2011 and 8/12/11 were reviewed and reflected a total of ten individuals discussed for polypharmacy (#139, #2, #12, #54, #31, #63, #150, #118, #94, and #27). The Clinical Director was absent from both meetings. The clinical review included a list of psychotropic and non-psychotropic medications, a discussion of polypharmacy issues, and an action plan. Based on review of the discussion and action plan, the Monitoring Team determined that the review lacked a comprehensive review that would enable prudent management of polypharmacy. For example: Individual #139 was prescribed Ativan, paroxetine, Seroquel, and Navane; the only comment was "Pt does meet definition of polypharmacy. Last quarterly psychotropic drug review was 5/16/2011." The Action plan was "none". A statement as to longitudinal behavioral trends, rationale for use, potential risks and benefits, and a long-term plan should be documented. Individual #2 was prescribed Haldol and Zyprexa. The Committee commented "Pt does not meet criteria for polypharmacy due to being on one atypical and one typical," and "Pt is on MOM and docusate. Need for stool softener and laxative questioned and referred to Dr. O'Donnel for review. The action plan stated "Referred to Dr. O'Donnel to review MOM and Docusate". The use of two antipsychotics is specifically stated in this provision as requiring review. As this committed is part of the facility-level review, this prescription of two antipsychotic medications must be reviewed by the committee. Individual #12 was prescribed Haldol and Zyprexa. Minutes commented "pt has gone through medication changes. Per Pharmacist, pt does not meet definition of polypharmacy due to being on 1 typical and 1 atypical," and there was no action plan. The Settlement Agreement requires that "prescriptions of two or more psychotropic medications from the same general class to the same individual (e.g., two antipsychotics), and the prescription of three or more psychotropic medications, regardless of class, to the same individual" be reviewed. The committee must review the use of two antipsychotic medications. The Monitoring team was not provided a copy of the Polypharmacy Workgroup Committee Policy or operating procedure. Because the Facility had yet to complete a comprehensive review of polypharmacy, limited review of those discussed by the polypharmacy meeting, not being provided the Committee's policy or operating procedures, not considering multiple antipsychotics as	Noncompliance

#	Provision	Assessment of Status	Compliance
		same class, ,and minimal action plans, the Monitoring Team concluded that the Facility is not in compliance with Provision J.11, of the Settlement Agreement.	
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 requested and reviewed the following individuals to assess completeness of MOSES and DISCUS assessments: Individual 1: MOSES: 7/11/11 was completed by the nurse on 7/11/11, and signed by the physician on 7/19/11. The physician did not complete the prescriber review. Individual #5: DISCUS: 8/14/11 was completed by the nurse on 8/14/11, and noted to have increased in severity from four to five total score. The physician reviewed the DISCUS on 8/15/11 but did not complete the prescriber component of the DISCUS and did not comment on the increase in severity. Individual #11: MOSES: 4/20/11 was initiated by the nurse on 4/20/11 but only the vital signs were documented, while the assessment was not completed. The physician signed the MOSES on 4/26/11, and indicated that no action was necessary, despite the MOSES not being completed (this issue was verified by the Monitoring Team by direct review of the copy in the clinical record and discussion with staff). MOSES: 1/31/11 was competed by the nurse on 1/31/11 and signed by the physician on 2/1/11, however, the prescriber review was not completed. MOSES 2/25/11 was completed by the nurse on 2/25/11 and signed by the physician on 2/28/11, however, the prescriber review was not completed. Individual #19: DISCUS was initiated by the nurse on 2/3/11, however the nurse did not complete the evaluation component of the DISCUS.. The physician signed the DISCUS on 2/28/11, twenty-five days after the nurse referred the DISCUS for physician review. Also, the physician did not complete the conclusion of the DISCUS. Upon review of clinical records, the Monitoring Team observed that the MOSES and DISCUS were not completed as clinically indicated outside the regularly scheduled reviews. It is important to perform more frequent monitoring of side effects whenever there is an unexplained change in the condition of the Individual, such as a behavior exacerbation, acting less active as usual, and when there are functional changes noted, and when an antipsychotic medication is added, discontinued, or changed in dose. The Monitoring Team was unable to determine if the Facility had an effective system of responding to side effects of psychotropic medications, as there was no policy or procedure available that delineates how the Facility must respond to side effects. There was no policy, or procedure that describes how those who complete, and those who	Noncompliance

#	Provision	Assessment of Status	Compliance
		interpret, the MOSES and DISCUS regularly review the reliability of their assessments. The Facility must enhance its ability to appropriately complete side effect assessments, ensure that their use is more frequent when clinically indicated, and ensure that there is an effective system in place to respond to side effects of psychotropic medications before compliance can be established. For these reasons, the Monitoring Team concluded the Facility remains non-compliant with Provision J.12, 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 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.	Following review of Psychiatric evaluations for Individuals #140, #139, #84, #3, #66, #2, #54, #134, and #40, the Monitoring Team noted that all diagnoses reflect DSM diagnostic criteria. The Monitoring Team identified that psychiatric diagnosis and treatment plans did not take into consideration behavior data, data analysis, and were not conducted within the context of an IDT process. Psychiatrists were not actively involved in the PSP process, so objective symptoms or behavioral characteristics to be monitored, and timelines for therapeutic effects, were not clearly identified for the PST. For these reasons, the Monitoring Team concurs with the Facility, and agrees that the Facility is not in compliance with Provision J.13, of the Settlement Agreement.	Noncompliance
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	The Monitoring Team reviewed the consent process for psychotropic medications, which included a review of three completed consent forms for Individuals #76, #15, and #61. The consent form is purely a checklist that indicates information was provided to the Individual and Legally Responsible Person. The Monitoring Team could not find any documentation of what information was presented to the individual and Legally Authorized Representative (LAR) for the following issues:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	1. Potential consequences of not taking the medication were not delineated. 2. Expected benefits and targeted behaviors to monitor to determine efficacy where not documented. 3. Alternative treatments, including no treatment, were not documented. 4. The purpose of the medication was not listed. 5. Serious and most common side effects, including TD, NMS, and agranulocytosis were not documented. 6. There was no termination date for the consent. Informed consent is a means to ensure that individuals and their LARs are well informed about treatment. It is essential that such parties are well aware of the purpose of the medication; dose, route and frequency of the medication; who is prescribing and monitoring the medication; terms of the consent process, including an expiration date; alternative treatments, including no treatment and behavior approaches; target symptoms/behaviors that require monitoring to assess efficacy; well documented and explained serious side effects of the medication, especially TD, NMS, and agranulocytosis for antipsychotics; and the use of off-label use should be considered as a component of the consent process and/or well documented in the clinical record. The Monitoring Team concluded that the Facility is not in compliance with Provision J.14, of the Settlement Agreement.	
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's Standard Operating Procedure, ICF-MR 400-13, dated December 3, 2010, states that the Facility will ensure that "the neurologist and psychiatrist must coordinate the use of medications, through the PST process, when the medication is prescribed to treat both seizures and a mental health disorder." The Facility did not have a procedure that outlines how the Facility will accomplish this requirement. The Clinical Director informed the Monitoring Team that although the psychiatrist will always discuss potential medication changes with the neurologist, the Facility had yet to develop a formal process. For this reason, the Monitoring Team concluded that the Facility remains non-compliant with Provision J.15, of the Settlement Agreement.	Noncompliance

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

1. Ensure that the team reviews programs to minimize the need for pre-treatment sedation as part of the PSP process. (Provision J4)
2. Ensure that behavioral data is well integrated into psychiatric assessments and prior to prescribing non-emergency psychotropic medications. (Provisions J3, J8, and J10)
3. Ensure that the psychiatrist documents a physical examination and a medical review-of-systems at the time of a psychiatric assessment (vital signs can be by review of flow sheets, but must be documented). (Provision J6)
4. Ensure that behavioral data and behavioral intervention are always considered at the time of developing any psychiatric treatment plan. (Provision J8)

5. Develop a mechanism to involve psychiatrists in the PST process, when developing a positive support plan for individuals who receive psychiatric services. Ensure that psychiatrist, primary care physician and nurse regularly participate, at PST meetings to determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medications. Develop and implement a written policy or procedure to delineate this mechanism. (Provisions J4, J9, J10, and J13)
6. Ensure that the polypharmacy committee reviews all polypharmacy issues, maintains appropriate policies, procedures, and minutes of meetings. It is essential that standardized, meaningful data is collected for polypharmacy, stat medication review, use of anticholinergics and behavior data, and presented in a way that enables efficacious interpretation. Data must be archived longitudinally. (Provision J11)
7. Ensure more then regularly scheduled side effect monitoring is completed, when clinically appropriate. (Provision J12)
8. Ensure that the MOSES and DISCUS are appropriately completed by the nurse and reviewed by the physician. (Provision J12)
9. Ensure that there is a mechanism in place to respond to noted side effects. (Provision J12)
10. Establish a process that ensures regular assessment for inter-rater reliability of those responsible for completing and interpreting the MOSES and DISCUS assessment scales. (Provision J12)
11. The consent process for psychotropic medications must be immediately enhanced to meet generally accepted requirements for informed consent. (Provision J14)
12. The Facility must either include off-label uses of treatments within the consent, and/or ensure robust documentation of its use in the clinical record. (Provision J14)
13. Ensure that a process is developed to facilitate collaboration between neurologist and psychiatrists, when medications are administered for comorbid mental health and neurological conditions. The process must be in the context of a PST venue, to ensure that the PSP clearly delineates the provider's recommendations. (Provision J15)

The following are offered as additional suggestions to the Facility:

1. Strongly consider the hire of a permanent full time psychiatrist, to assume the Locum Tenens position
2. When reviewing polypharmacy issues, it would be advantageous for the Facility, and Individuals served, if non-psychotropic polypharmacy was also addressed.

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement (POI) 8/09/11 2. RGSC Section K Evidence Book 3. Minutes for the Behavior Management Committee (3/31/2011 – 06/23/2011) 4. Contracts for professionals providing external peer review, and intellectual and adaptive assessment 5. Documents that were reviewed included the annual PSP, PSP updates, Specific 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: #1, #3, #5, #8, #11, #12, #33, #35, #36, #40, #51, #58, #61, #76, #80, #96, #97, #118, #133, and #140. **People Interviewed:** 1. Megan Gianotti, M.Ed. – Behavioral Services Director 2. David Moron, MD – Medical Director 3. Belinda Allen – Active Treatment Monitor 4. Lorraine Hinrichs – Program Director 5. Cheryl Fielding, Ph.D. – BCBA consultant 6. Janie Villa – QDDP Coordinator 7. All QDDPs 8. Direct Care Professionals (DCPs): Approximately 15 staff members in residences, classrooms and vocational settings **Meeting Attended/Observations:** 1. Risk Management Meeting – 8/22/2011 and 8/24/2011 2. Polypharmacy Workgroup – 8/24/2011 3. Behavior Management Committee – 8/25/2011 4. Human Rights Committee – 8/25/2011
	Facility Self-Assessment: The Facility's Plan of Improvement indicated it was not in compliance with any Provisions This was consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. The Facility's Self-Assessment information as reported was inadequate to determine the progress made toward compliance for all provisions; most information was repeated from the last two reviews. The information contained for the various provisions did not always relate to the Settlement Agreement requirements for the specific provisions. There were no relevant observable or measureable data contained in the self-assessment data that indicated how those activities were moving the Facility toward compliance within the respective provisions. There was no clear sequential framework or timelines

	established to identify how they expected to reach and maintain compliance. The Facility's POI contained a summary of action plans on which they were working to achieve compliance. The action plans were not specific and failed to consistently relate to the requirements of the provisions in the Settlement Agreement. Furthermore, there were instances when the POI and action plans were inaccurate. For example, the Facility indicated that progress had been achieved in the Peer Review process and staff training that could not be substantiated during the site visit. Also, there was no identification of data that would be used to demonstrate compliance. The Facility needs to ensure that the activities and action steps included in the POI reflect the requirements set forth in the Settlement Agreement for that specific provision. Through a review of the Presentation Book for Section K, record reviews, interviews, and observations the Monitoring Team was able to validate that some of the activities listed in the Facility's Self-Assessment were carried out and showed improvement in moving the Facility toward compliance for some of the provisions. For example, it was evident that some progress had been achieved in the assessment of intellectual and adaptive abilities. In addition, data graphs had continued to progress toward compliance with the SA. These activities and improvements were discussed in the Monitor's Assessment and throughout the report.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RGSC from 8/22/2011 through 8/26/2011. Record reviews continued off-site following the site visit. Based upon the information gathered, it was determined that no provisions were in substantial compliance with the SA. One of the most substantial issues noted by the Monitoring Team was the ongoing inability of the Facility to ensure that DCP staff conducted formal and informal training. No observations conducted during the site visit revealed DCP staff implementing PBSPs or collecting behavior data. In some circumstances, staff were observed to not intervene when conditions met the requirement for intervention in the PBSP. Documents revealed that numerous errors were found in behavior data over a two-month period, including failures to record displays of problem behavior or recording behavior displays in the records of the incorrect individual. Because of the failure to ensure the provision of behavior services, individuals living at the facility were unlikely to experience an improved quality of life. Where individuals were known to engage in potential dangerous behavior, the lack of consistent intervention increased the potential of harm for the individuals living at the Facility. It was also noted that RGSC continued to experience limitations in reviewing the quality of PBSPs. The Behavior Management Committee (BMC), which had been reported previously as no longer providing clinical review, was observed during the site visit as functioning in that capacity. As the BMC lacked staff qualified to review clinical aspects of PBSPs, the Facility had allowed PBSPs to be implemented without thorough review. RGSC had arranged for external peer review of PBSPs. An audit of PBSPs recently subject to external peer review, however, revealed the external review process to provide minimal input from the reviewer.

	The site review also revealed that evidence-based practices were not consistently applied at RGSC in relation to behavior interventions. Records for several individuals with challenging behaviors and/or mental illness were reviewed. These records reflected that treatment decisions were often not based upon available data, including failures to revise ineffective PBSPs and changes in psychotropic medications that were not supported by assessments or treatment data. Observations, interviews, and documentation suggested that one factor contributing to the limitations at RGSC was the lack of qualified psychology staff. Only the Psychology Director had extensive experience in behavior analysis, and much of her time was consumed with administrative responsibilities. The remainder of the Psychology Department staff, although dedicated, lacked the experience or training to function independently in the development and implementation of behavior interventions. As a result, the availability of demonstrably competent staff was inadequate to the needs of the people living at the Facility. Information gathered as part of the site visit clearly indicated that RGSC continued to struggle with achieving compliance with the SA. Several areas reviewed reflected only slight improvement over baseline conditions observed in March of 2010. In other areas, the Facility had failed to maintain earlier achievements.

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	At the time of the site visit, RGSC employed two psychology staff with Master's degrees: Megan Gianotti, M.Ed. (Psychology Department Director) and Vanessa Villareal, M.Ed. (Associate Psychologist). Ms. Gianotti had completed coursework and supervision required to become a BCBA and had applied to sit for the board certification exam. Ms. Villareal had no prior experience in applied behavior analysis or intellectual and developmental disabilities. Since being hired, Ms. Villareal had enrolled in classes required to obtain BCBA credentialing. 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. Villareal completes training and earns board 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	As indicated in Provision K1, RGSC employed Megan Gianotti, M.Ed. as Psychology Director. Ms. Gianotti was a long-term employee of RGSC prior to accepting the role of	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Director of Behavioral Services. Prior to her employment at RGSC, she had worked with individuals diagnosed with autism spectrum disorders, developing and implementing behavior interventions. During the current site visit, Ms. Gianotti demonstrated broad knowledge of applied behavior analysis. She was familiar with the published research and demonstrated well-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. At the time of the site visit, Ms. Gianotti had completed coursework and supervision required to become a BCBA and had applied to sit for the board certification exam. 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.	The role of the peer review committee has been briefly defined in the professional literature as follows. *"In cases in which withholding or implementing treatment involves potential risk, Peer Review Committees and Human Rights Committees play distinct roles in protecting client welfare. Peer Review Committees, comprised of experts in behavior analysis, impose professional standards to determine the clinical propriety of treatment programs." (The Right to Effective Behavioral Treatment. Van Houten, R. et.al. 1988. Journal of Applied Behavior Analysis, 21, 381-384.* In order to meet these goals, an organization or Facility must ensure that the necessary resources are available, policies and procedures are implemented, and demonstrably competent staff participate. In addition, steps must be taken to ensure that the implementation of peer review does result in interventions that adhere to acceptable practices. During the August 2010 site visit, the Facility reported that an internal peer review process was in place and functioning under the auspices of the Behavior Management Committee (BMC). 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. Since the August 2010 site visit, RGSC had removed the peer review responsibilities from the BMC. Although still functioning, the BMC, according to interviews in August 2010, no	Noncompliance

#	Provision	Assessment of Status	Compliance
		longer had the responsibility of reviewing PBSPs for clinical acceptability. Observations during the 2011 site visit to RGSC, as well as a review of BMC minutes, reflected that the BMC continued to function with the authority and responsibility of an internal peer review committee. As such, there were noted to be substantial weaknesses in the BMC procedures in a meeting convened during the site visit. • The meeting was chaired by a Facility employee who was not a BCBA, was not a member of the Psychology Department, and lacked training and experience in applied behavior analysis. • Other than Megan Gianotti, no one present at the BMC meeting possessed extensive knowledge or experience in applied behavior analysis. • Professionals likely to possess valuable insight into the behavior change process and strategies, such as the Pharmacist and Psychiatrist, were not present at the meeting. • The PBSP for Individual #80 was reviewed during the meeting. The following limitations in the review were noted. o Environmental factors were identified in the PBSP as motivating factors in displays of aggression and self-injury. Additionally, non-psychotropic interventions were associated with decreasing trends in self-injury and aggression. Nevertheless, the BMC raised no questions about the introduction of lithium and Tegretol during improvement in the target behaviors. o BMC discussions were subjective and rarely involved data or formal assessment. o Agitation, aggression, and self-injury were identified in the behavior assessment as often resulting from being moved out of desired environments or preferred activities. In many cases, the individual was moved due to staff preference rather than an identified need. The BMC supported the addition of communication training for the individual but did not recognize or address the failure of staff to offer choices in order to avoid undesired behavior. Based upon the information presented above, it was evident that the Facility allowed the BMC to continue to function in a peer review capacity even though the BMC failed to meet the requirements of a peer review committee and continued to demonstrate weaknesses such as a lack of 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. As a result, the Facility had allowed PBSPs to be reviewed, revised and implemented without thorough internal review. The Facility also indicated that external peer review was provided: Cheryl Fielding, PhD,	

#	Provision	Assessment of Status	Compliance
		the BCBA consultant for the Facility, was serving as the provider of external peer review. In this capacity, Dr. Fielding was expected to review 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. The external peer review process utilized a checklist to rate the Structural/Functional Assessment (SFA) and PBSP. An examination of the checklist document did not reveal that the checklists were adequate for the task of providing external peer review. Specifically, the following concerns were raised. • The structure of the checklist consisted primarily of rating whether specific sections of the SFA and PBSP were included in the submitted documents. • The checklist provided neither a process nor criteria for a qualitative review of the SFA and PBSP. Without a qualitative review, the potential benefit of the peer review process is substantially curtailed. • No instructions for the external peer reviewer or interpretive guidelines for a later reader were provided. • The comment/recommendation box included on the form was too small to allow for adequate documentation of the review process. • The form included no process to document how recommendations were addressed or whether additional review would be needed. To assess the quality of the external peer review process, the checklists from the four most recent external peer review submissions were selected as a sample. Four submissions consisted of eight forms; four forms for the SFAs and four forms for the PBSPs. This sample reflected a variety of weaknesses. • The comments and recommendations from the four submissions consisted of 49 words, an average of slightly more than six words per form. As the goal of a peer review process is to educate as well as identify potential clinical limitations, six words per form was unlikely to convey meaningful insights and serve the purpose of peer review. • The majority of comments consisted of generic praise for the SFA or PBSP. • The sample included a total of 184 checklist items, 46 per submission. Of these 184 items, only four or slightly more than 2% were indicated to be inadequate by the peer review process. A peer review process that revealed limitations in only 2% of rated areas would suggest that the SFAs and PBSPs were of high quality. A review of the same SFAs and PBSPs included in the peer review submissions was conducted by the Monitoring Team. The process used by the Monitoring Team included an assessment of the quality, as well as	

#	Provision	Assessment of Status	Compliance

the inclusion, of required content based upon the rating instrument developed by the SA Monitoring Team for Section K. The results of that review indicated that the external per review obtained by the Facility failed to identify substantial limitations in the SFAs and PBSPs. The items from the Section K Monitoring Instrument, as well as results obtained by the Monitoring Team during the site visit, are presented in the table below. An "X" indicates an item that was found to satisfy the expectations of the SA.

Structural/Functional Assessment	Individual #			
	3	11	97	133
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis.				
The process or tool utilizes both direct and indirect measures.				x
Differentiation between learned and biologically based behaviors.				
Identification of setting events and motivating operations relevant to the undesired behavior.				
Identification of antecedents relevant to the undesired behavior.			x	
Identification of consequences relevant to the undesired behavior.				
Identification of functions relevant to the undesired behavior.				
Summary statement identifying the variable or variables maintaining the target behavior.				
Identification of functionally equivalent replacement behaviors relevant to the undesired behavior.				
Identification of preferences and reinforcers.				

Positive Behavior Support Plans	3	11	97	133
Rationale for selection of the proposed intervention.				
History of prior intervention strategies and outcomes.				
Consideration of medical, psychiatric and healthcare issues.				
Operational definitions of target behaviors.	x	x	x	x
Operational definitions of replacement behaviors.			x	x
Description of potential function(s) of behavior.				

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
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<tr><td>Use of positive reinforcement sufficient for strengthening desired behavior</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Strategies addressing setting event and motivating operation issues.</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Strategies addressing antecedent issues.</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Strategies that include the teaching of desired replacement behaviors.</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Strategies to weaken undesired behavior.</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Description of data collection procedures.</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Baseline or comparison data.</td><td></td><td></td><td>x</td><td></td></tr>
<tr><td>Treatment expectations and timeframes written in objective, observable, and measureable terms.</td><td></td><td></td><td>x</td><td>x</td></tr>
<tr><td>Clear, simple, precise interventions for responding to the behavior when it occurs.</td><td></td><td></td><td></td><td>x</td></tr>
<tr><td>Plan, or considerations, to reduce intensity of intervention, if applicable.</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Signature of individual responsible for developing the PBSP.</td><td>x</td><td>x</td><td>x</td><td>x</td></tr>
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Based upon the information obtained from observations and record reviews, it was evident that considerable limitations existed in the peer review process at RGSC. Substantial effort by the Facility will be necessary to ensure that adequate peer review is provided.
</td><td></td></tr>
<tr><td>K4</td><td>Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored</td><td>As during the previous site visit, observations and documentation reviewed during the current 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. In many cases, the data collection strategy had been tailored to the specific nature of the individual's behavior. The combination of formal strategies and individualization suggested an approach to behavior intervention that was based upon behavior analytic principles.

Despite an abundance of data collection tools and procedures, RGSC continued to display substantial limitations in the quality of behavior data collected. From a sample of 13 PBSPs, the following conditions were noted.
<table>
<tr><td></td><td>Baseline</td><td>8/2011</td><td>Change</td></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress.</td><td>0%</td><td>62%</td><td>62%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.		

Replacement behavior data collection sufficient to assess progress.	0%	8%	8%
Data reliability is assessed.	0%	0%	0%
Target behaviors analyzed individually.	0%	38%	38%
Targeted behaviors graphed sufficient for decision-making.	0%	92%	92%
Replacement behaviors graphed sufficient for decision-making.	0%	23%	23%

Some improvement in the data collection and treatment monitoring process was noted. For example, the data collection process was adequate to the task of determining the benefit from behavior interventions in 62% of the records sampled. In the remaining 38% of records, the data collection process involved collecting frequency data for targets that are better measured in terms of duration or severity. For example:

- The PBSP for Individual #1 included behavior associated with mood disorder as a target. These behaviors included pacing, interrupted sleep, a blank stare, mumbling to self, and hypersexuality: All data on these targets were reported as frequency. Frequency data are best used for behaviors that are displayed as brief events with a clear beginning and ending. The targets listed above were ongoing events that could last for minutes or hours, and for which it would be difficult to determine when the behavior had begun or ended.

Although graphed data for targeted, undesired behaviors were available for 92% of the records reviews, graphed data for replacement behaviors was seen in less than 25% of the sampled records.

- For individual #8, no data were reported regarding replacement behaviors.
- For Individual #58, it was not possible to determine if no data on replacement behavior were collected or if data were not graphed.

Problems were also noted in the manner in which data were used to assess responses to treatment. From a sample of 13 PBSPs, the following conditions were noted:

	Baseline	8/2011	Change
Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level.	0 %	69%	69%
Review is conducted by a BCBA.	0%	0%	0%
Input from direct care staff is solicited and documented.	0%	0%	0%

#	Provision	Assessment of Status	Compliance

Modifications to the PBSP reflect data-based decisions.	0%	15%	15%
Criteria for revision are included in the PBSP.	0%	8%	8%
Either progress was evident, or program was modified in timely manner (3 Months).	0%	15%	15%

A substantial issue noted in the records involved the failure to use available data in determining whether an individual was displaying a reduction in target behavior following the introduction of an intervention. In several of the reviewed documents, data did not reflect improvement following a change in treatment. In other circumstances, individuals were noted to display worsening behavior following a change in treatment, but data did not reflect an effort to stop or revise the ineffective treatment method.

- For Individual #8, a new PBSP was implemented in September 2010. By March 2011, reported monthly incidents of aggression had increased from zero to nine. The PBSP was not revised until May 2011.
- For Individual #36, target behaviors remain at a high level for one year without a review of the need for revision to the intervention.
- For Individual #51, aggression increased abruptly in January 2011. The recommendation was to monitor for 1 month before initiating new assessments. Before the recommended month elapsed, Risperdal was prescribed for the individual to target aggression. The rate of aggression remained essentially unchanged for five months without a review of the need for Risperdal.

Perhaps the greatest problem in relation to intervention data involved the failure of staff to accurately document displays of behavior. It was reported by Psychologists, QDDPs, and Active Treatment staff that DCP staff consistently failed to document behavior displays according to the PBSP instructions and data collection training. In addition, records and documentation reflected consistent problems with the data collection.

Between 6/1/2011 and 7/31/2011, 129 Request for Documentation Correction forms were completed and submitted to DCP employees by Behavior Services staff. Each Request for Documentation Correction form reflected at least one data error: Several reflected multiple data errors. These errors included multiple occurrences of the following.

- Staff failed to record the time, date, duration, and/or location of the behavior display.
- Staff documented a display of a target behavior in the records for the wrong individual.
- The target behavior was not documented on the Behavior Data Sheet.
- The target behavior was not documented in the CWS Behavior Event Progress

#	Provision	Assessment of Status	Compliance
		Note. Multiple attempts were made by Psychology Department staff to improve the quality of data collection. Multiple training sessions were conducted for each PBSP. Special, intensive training was scheduled for specific topics and special issues. Training content was enhanced with role-playing and other hands-on methods. Special laminated cards that listed the interventions and data collection procedures for each PBSP, as well as basic behavioral practices, were provided to DCP staff. The efforts by the Psychology Department to improve data collection were ineffective. Facility emails documented on-going complaints regarding the schedule for DCP training on PBSPs despite repeated efforts to schedule the training at times convenient to DSP staff. The laminated cards were not distributed to DSP staff for several weeks after the Psychology Department made the cards available. Observations by the Monitoring Team during the site visit did not capture any staff documenting undesired behavior. In addition, no staff member was observed to be carrying or referencing the PBSP reference cards. The observations by the Monitoring Team did capture several displays of undesired behavior for which documentation was to have been completed. Data recording may have occurred following the observation by the Monitoring Team, but late documentation by memory is not considered acceptable practice as it can substantially degrade the reliability of data. Failure to document behaviors targeted by PBSPs appropriately often can make it extremely difficult to evaluate the effectiveness of treatment programs through an accurate review of progress or lack of progress, and can increase the potential that ineffective or even harmful treatment programs and practices will continue. It is imperative that RGSC act diligently to improve the data collection process and ensure that individuals living at the Facility are provided with adequate, evidence-based behavior services.	
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	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. This is the same percentage documented in February of 2011. In August 2010, only 40% of individuals had not received psychological assessment in the previous 12 months. These data indicated that RGSC had failed to improve compliance with this provision of the SA. Some effort had been demonstrated by the Facility to improve the frequency and content the psychological assessments. Contracts had been signed with two consultants to complete assessments of cognitive ability and adaptive behavior. At the time of the site visit, some initial assessments and reports had been completed. The process was	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>that may require intervention.</td><td>evolving slowly, and several logistical issues, such as the process for merging multiple reports, remained to be addressed.

A sample of the six most recent psychological assessments was selected to audit the content of the psychological assessment reports. The sample revealed modest progress was achieved toward ensuring that adequate assessment scores for cognitive ability and adaptive skills were included in reports. This progress was welcome. As these reports were developed by the consultants hired to ensure compliance, it was not encouraging that these reports did not reflect 100% compliance. The reports also often reflected a lack of interpretation of the assessment findings. As a result, the assessments were unlikely to contribute to the overall assessment of the individuals or contribute to the development of skill acquisition programs.

<table>
<tr><th></th><th>Baseline</th><th>8/2011</th><th>Change</th></tr>
<tr><td>Standardized assessment or review of intellectual and cognitive ability.</td><td>0%</td><td>33%</td><td>33%</td></tr>
<tr><td>Standardized assessment of adaptive ability.</td><td>0%</td><td>33%</td><td>33%</td></tr>
<tr><td>Screening for psychopathology, emotional and behavioral issues.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Assessment or review of biological, physical and medical status.</td><td>0%</td><td>23%</td><td>23%</td></tr>
<tr><td>Review of personal history.</td><td>11%</td><td>38%</td><td>27%</td></tr>
<tr><td>Psychological Assessments contained findings from an intellectual test administered within the previous five years.</td><td>0%</td><td>33%</td><td>33%</td></tr>
<tr><td>Psychological Assessments included a narrative summary of how the results from intellectual assessments more than five years prior would facilitate the understanding of the individual’s strengths and needs.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.</td><td>0%</td><td>33%</td><td>33%</td></tr>
<tr><td>Psychological Assessments included a narrative summary of how the results from adaptive assessments current or otherwise would facilitate the understanding of the individual’s strengths and needs.</td><td>0%</td><td>0%</td><td>0%</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>During the current site visit, a sample of 13 Structural and Functional Assessments (SFAs) was selected. Modest improvement over baseline was noted in several areas.

<table>
<tr><th></th><th>Baseline</th><th>8/2011</th><th>Change</th></tr>
<tr><td>A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis.</td><td>0%</td><td>38%</td><td>38%</td></tr>
<tr><td>The process or tool utilizes both direct and indirect measures.</td><td>0%</td><td>54%</td><td>54%</td></tr>
<tr><td>Differentiation between learned and biologically based behaviors.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Identification of setting events and motivating operations relevant to the undesired behavior.</td><td>0%</td><td>31%</td><td>31%</td></tr>
<tr><td>Identification of antecedents relevant to the undesired behavior.</td><td>0%</td><td>46%</td><td>46%</td></tr>
<tr><td>Identification of consequences relevant to the undesired behavior.</td><td>0%</td><td>38%</td><td>38%</td></tr>
<tr><td>Identification of functions relevant to the undesired behavior.</td><td>0%</td><td>38%</td><td>38%</td></tr>
<tr><td>Summary statement identifying the variable or variables maintaining the target behavior.</td><td>0%</td><td>46%</td><td>46%</td></tr>
<tr><td>Identification of functionally equivalent replacement behaviors relevant to the undesired behavior.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Identification of preferences and reinforcers.</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>

The majority of the SFAs reflected that the assessment followed a general process accepted within the field of applied behavior analysis. The SFA process often included direct and indirect assessment procedures, made use of accepted tools, and resulted in hypotheses regarding the function of the target behavior. A substantial weakness noted, however, was the failure to apply the principles behind this process fully. In many cases, the assessment process did not include a sufficient number of observations, did not address conflicting findings, and failed to support the hypotheses generated,
• For Individual #3, the following problems were noted:
o Direct observations did not capture any displays of the target behaviors.
o The FAST indicated multiple functions for the target behaviors. No additional assessment was completed to identify which functions were most likely.
• For Individual #11, the following weaknesses were noted:
o Direct observations captured only one display each for aggression and</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance

SIB. Such a limited observation does not allow for adequate assessment that can confirm staff reports and assist in development of valid hypotheses regarding function.

- Observations were conducted 4 months prior to the SFA. Documentation reflected a substantial change in the target behaviors between the time of the observations and the completion of the SFA.

- For Individual #58, the following weaknesses were noted:
  - The SFA included a recommendation that a reinforcer assessment be completed. A reinforcer assessment should be part of the SFA, not a recommendation.
  - The replacement behaviors identified by the SFA were behaviors that were incompatible or physically could not be performed at the same time as the target behavior. Strengthening an incompatible behavior is an accepted behavior change procedure. In this situation, however, the incompatible behavior was identified as a replacement behavior even though it did not serve the same function as the target behavior.

An additional weakness noted in the SFAs during the site visit was the failure to apply the SFA process to understand better the behaviors that were associated with mental illness. Although in many cases mental illness was mentioned in the SFA narrative, in none of the 13 sample SFAs was the functional assessment process applied to these behaviors.

- For individual #58, the only assessment of mental illness involved a mental status exam and clinical interview. As the individual is primarily non-verbal, the assessments were unlikely to provide valuable insights. No further investigation was completed.
- For Individual #61, the SFA did not address the diagnosed mental illness.
- For Individual #133, mental illness is discussed as a setting event in the narrative of the SFA. No assessments were conducted to investigate further the role of mental illness or to support the information in the narrative.

	Baseline	8/2011	Change
Identification of behavioral indices of psychopathology	0%	0%	0%
Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities	0%	0%	0%

Based upon the information gathered during the site visit, it was evident that improvement had been achieved in the assessment of behavior and the SFA process. The

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>noted limitations, however, indicated that further work will be required in order to achieve compliance with the SA.</td><td></td></tr>
<tr><td>K6</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.</td><td>Based upon the information presented in K5, documentation reflected assessments were not current, accurate, or complete.</td><td>Noncompliance</td></tr>
<tr><td>K7</td><td>Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.</td><td>Records reflect that individuals newly admitted to the Facility had a psychological assessment completed within 30 days of admission. Records do 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.
<table>
<tr><th></th><th>Baseline</th><th>8/2011</th><th>Change</th></tr>
<tr><td>Individual records demonstrate that these psychological assessments are conducted as often as needed, and at least annually, for each individual.</td><td>0%</td><td>15%</td><td>15%</td></tr>
<tr><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>89%</td><td>100%</td><td>11%</td></tr>
</table></td><td>Noncompliance</td></tr>
<tr><td>K8</td><td>By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.</td><td>No individuals living at RGSC at the time of the site visit were participating in counseling or psychotherapy. There was no indication in documents provided to the Monitoring Team that this was reviewed for any individual by the PST or that counseling had been considered.</td><td>Noncompliance</td></tr>
<tr><td>K9</td><td>By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary</td><td>The records of 13 individuals were reviewed regarding consents for restrictive procedures, including in behavior and psychotropic interventions. In the cases reviewed, 85% of the individuals who required consent had acceptable consents in their charts. This is an improvement of seven percent over baseline. For the remaining individuals,</td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.</td><td>the approvals and consent had not been obtained appropriately.
• For Individual #12, the BMC review document did not indicate whether approval had been given.
• For individual #51, the PBSP was revised following obtaining the necessary approvals and consents.

At baseline, the Facility indicated that 78% of PBSPs were implemented within 14 days of obtaining approvals. During the most recent site visit, documentation indicated the Facility had made no improvement over baseline. Current documentation showed that 77% of PBSPs were implemented within 14 days of obtaining consent and that 23% of PBSPs were not implemented in a timely manner.

<table><tr><td></td><td>Baseline</td><td>8/2011</td><td>Change</td></tr><tr><td>Necessary consents and approvals are obtained for each PBSP and safety plan prior to implementation.</td><td>78%</td><td>85%</td><td>7%</td></tr><tr><td>Within 14 days of obtaining consents, the PBSP or safety plan will be implemented.</td><td>78%</td><td>77%</td><td>-1%</td></tr></table>
The majority of PBSPs reviewed at RGSC included steps to address all aspects of the contingencies of the undesired target behaviors. Without rigorous and comprehensive assessment, however, these proposed steps relied primarily upon subjective opinion and educated guesses. The lack of adequate assessment reduces the probability that the PBSP will be effective and holds the potential to precipitate the eventual use of more intrusive procedures. In situations where undesired behavior could result in risk of harm to the individual or their peers, there existed the potential for an inadequate behavioral intervention to allow a possibly harmful behavior to continue.

A sample of 13 PBSPs was selected from the most recent interventions completed at RGSC. The information below summarizes the limitations noted during the review.

<table><tr><td></td><td>Baseline</td><td>8/2011</td><td>Change</td></tr><tr><td>Rationale for selection of the proposed intervention.</td><td>0%</td><td>31%</td><td>31%</td></tr><tr><td>History of prior intervention strategies and outcomes.</td><td>0%</td><td>23%</td><td>23%</td></tr><tr><td>Consideration of medical, psychiatric and healthcare issues.</td><td>0%</td><td>8%</td><td>8%</td></tr><tr><td>Operational definitions of target behaviors.</td><td>0%</td><td>69%</td><td>69%</td></tr><tr><td>Operational definitions of replacement behaviors.</td><td>0%</td><td>23%</td><td>23%</td></tr></table></td><td></td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Description of potential function(s) of behavior.</td><td>0%</td><td>31%</td><td>31%</td></tr>
<tr><td>Use of positive reinforcement sufficient for the strengthening of desired behavior.</td><td>0%</td><td>23%</td><td>23%</td></tr>
<tr><td>Strategies addressing setting event and motivating operation issues.</td><td>0%</td><td>31%</td><td>31%</td></tr>
<tr><td>Strategies addressing antecedent issues.</td><td>0%</td><td>38%</td><td>38%</td></tr>
<tr><td>Strategies that include the teaching of desired replacement behaviors.</td><td>0%</td><td>31%</td><td>31%</td></tr>
<tr><td>Strategies to weaken undesired behavior.</td><td>0%</td><td>15%</td><td>15%</td></tr>
<tr><td>Description of data collection procedures.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Baseline or comparison data.</td><td>0%</td><td>15%</td><td>15%</td></tr>
<tr><td>Treatment expectations and timeframes written in objective, observable, and measureable terms.</td><td>0%</td><td>15%</td><td>15%</td></tr>
<tr><td>Clear, simple, precise interventions for responding to the behavior when it occurs.</td><td>11%</td><td>54%</td><td>43%</td></tr>
<tr><td>Plan, or considerations, to reduce intensity of intervention, if applicable.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Signature of individual responsible for developing the PBSP.</td><td>11%</td><td>85%</td><td>74%</td></tr>
</table>

Based upon this information, it was evident that at best, the Facility had achieved modest improvement in a limited number of items relating to PBSPs. Overall, when combined with the noted limitations in the functional assessments, it was improbable PBSPs were able to produce meaningful changes in behavior.
</td><td></td></tr>
<tr><td>K10</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic</td><td>As noted in Provision K4, the quality of behavior data at RGSC was questionable due to failures to comport with current, generally accepted practices. In addition, difficulties were described in ensuring that staff completed data collection on behavior interventions. Specific information about the quality of behavior data was unavailable, however, as reliability measures of interobserver agreement (IOA) were not in place at the Facility. Although the Facility had initiated a process of data integrity checks in August 2011, this was recent; there were only 14 reported observation of staff data collection. Observations reflected whether a behavior was documented and whether the documentation process was used correctly. There was no information regarding data taken by an independent observer or degree of agreement, just "yes" or "no." These 14 observations were then calculated as percentages. This did not constitute determination of interobserver agreement that would permit evaluation of observability and clarity of behaviors observed and accuracy of data. This lack of reliability measures reflected that the Facility had made no progress since the baseline site visit. As reliability data were not</td><td>Noncompliance</td></tr>
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<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>medications.</td><td>collected, data graphs did not include measures of reliability.

<table>
<tr><td></td><td>Baseline</td><td>8/2011</td><td>Change</td></tr>
<tr><td>IOA for target behavior data</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>IOA for replacement behavior data</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>IOA meets minimum expectations</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>

Apart from weaknesses in the quality of behavior data, observations and document reviews during the current site visit reflected that the Facility had achieved substantial improvement in behavior data graphs.

<table>
<tr><td>Graph Element</td><td>Baseline</td><td>8/2011</td><td>Change</td></tr>
<tr><td>Data Graphed at least monthly</td><td>0%</td><td>92%</td><td>92%</td></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>0%</td><td>38%</td><td>38%</td></tr>
<tr><td>Horizontal axis and label</td><td>0%</td><td>92%</td><td>92%</td></tr>
<tr><td>Vertical axis and label</td><td>0%</td><td>69%</td><td>69%</td></tr>
<tr><td>Condition change lines</td><td>0%</td><td>77%</td><td>77%</td></tr>
<tr><td>Condition labels</td><td>0%</td><td>77%</td><td>77%</td></tr>
<tr><td>Data points and path</td><td>0%</td><td>69%</td><td>69%</td></tr>
<tr><td>IOA and data integrity</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Demarcation of changes in medication, health status or other events</td><td>0%</td><td>77%</td><td>77%</td></tr>
</table>

The greatest problem noted in the behavior data graphs other than reliability involved measurement procedures and how some data were presented on the graphs. In several situations, symptoms of mental illness were measured and graphed as frequency data. In circumstances where the behavior reflecting mental illness occurs in brief, discrete displays, a frequency count may be appropriate. The measures of mental illness of concern at RGSC involved frequency counts of longer duration events, such as delusions, hallucinations, and sadness, that lacked easily identified beginnings and endings. Frequency measures for these mental illness symptoms could potentially mask the severity of the mental illness and adversely alter treatment decisions. Additional information on this issue was presented in Provision K5.

Based upon the current site visit, despite the technical improvements in the data graphs, the data graphs at RGSC were inadequate to the task of developing treatment decisions.</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	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. Despite readable PBSPs and acknowledgement by DSP staff that PBSPs were not difficult to understand, numerous incidents of PBSPs not being implemented were reported by Psychology staff and QMRPs. In addition, observations by the Monitoring Team did not capture any staff in the act of implementing a formal PBSP even when circumstances warranted that the PBSP be implemented. • The PBSP for Individual #40 called for staff providing 1:1 supervision to ensure that abundant, enthusiastic attention was offered as frequently as possible. Observations conducted in the Residence 501 dining room on August 22 reflected that the assigned 1:1 staff member offered Individual #40 no interaction for over 20 minutes despite the individual displaying increasing physical arousal and agitation. It was not until the individual threatened physical violence that the 1:1 staff member offered interaction. The failure to implement behavior interventions consistently and effectively 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.	Noncompliance
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.	During the current site visit, both reports by staff and Facility documentation reflected that competency-based training had not been fully implemented. Although preliminary steps had been taken toward the development of training materials and curriculums, the actual training had not been initiated.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	the requirement of one BCBA for every 30 individuals living at the Facility, based upon the current facility census. 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.	

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

1. The Facility needs to act to ensure that an adequate number of demonstrably-competent psychologists or behavior analysts are available for the delivery of psychological services.
2. RGSC needs to aggressively act to ensure that PBSPs are implemented and treatment data are consistently and accurately collected.
3. Efforts should be made to ensure that the external peer review process encompasses all relevant components of behavior assessment and intervention. Additionally, the peer review process should provide sufficient feedback to allow for education and the clear communication of training program needs.
4. RGSC needs to clarify the role of the BMC and act to ensure that thorough review of behavior interventions is provided.
5. The Facility needs to accelerate the cognitive and adaptive assessment process, as well as develop specific guidelines for assessment procedures and report contents.
6. Efforts should be made to formalize the assessment and diagnosis process for mental illness. This assessment and diagnosis process should include the use of instruments designed for use with people with intellectual and developmental disabilities, make rigorous use of functional assessment to differentiate between learned behaviors and internally driven symptoms of mental illness, and include procedures for the clear identification of targets best used for the measurement of treatment efficacy.
7. 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.
8. The Facility needs to review the circumstances creating the delay in PBSP implementation after approvals and consent have been obtained.
9. Specific treatment expectations, including target dates and specific clinical indicators, must be included in the intervention plans and integrated into the intervention review process. Current practices have resulted in decisions lacking a clinical basis or justification.
10. The PBSPs often fail to reflect or address the basic assumptions of applied behavior analysis, such as 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.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Plan of Improvement, dated 8/9/11 2. Active clinical records of Individuals #74, #94, #140, #1, and #72 **People Interviewed:** 3. David Moron, MD – Clinical Director 4. John Partin, MD – Primary Care Provider **Meeting Attended/Observations:** 1. Direct observations of the following Individuals: #74, #94, #140, # 1, and #72
	Facility Self-Assessment: The Monitoring Team reviewed the Facility's Plan of Improvement (POI), and met with, and discussed clinical issues with the Facility's new primary care physician and clinical director, and was informed that the Facility is not in compliance with Provision L, of the Settlement Agreement. After reviewing the POI, and conducting a comprehensive review of clinical activities and the Facility, the Monitoring Team concurs with the Facility's determination. The Monitoring Team finds that the action plans noted in the Facility's POI provide only a list of activities, and do not provide a meaningful plan of action that outlines steps that must be completed before compliance can be achieved.
	Summary of Monitor's Assessment: The Monitoring Team recognized the important steps taken to hire a physician who specializes in adult primary care medicine. The Monitoring Team clearly noted improvements in the area of addressing acute care medical problems, and addressing follow-up of many consultations and diagnostic reports. The newly hired primary care physician had just begun his assessment of chronic care issues of Individuals served by the Facility. Provision L1: During its review, the Monitoring Team noted that many chronic care issues, such as the management of diabetes, orthopedic and neuromotor conditions, bowel related conditions, and dysphagia, among others, required more assertive management. Importantly, there was no well defined organizational structure in place that enabled the efficacious delivery of primary care services. The Monitoring Team identified a significant lack of meaningful integration of health care services in the Personal Support Team process, which could lead to serious adverse outcomes. There was a lack of assertive evaluation to determine the underlying etiology of both acute and chronic conditions, and it is imperative to understand the etiology of such condition in order to definitely treat and/or prevent exacerbation and, worsening of the condition. For these reasons, the Monitoring Team determined that the Facility remained not in compliance with Provision L.1, of the Settlement Agreement. Provision L2: The Facility had yet to implement the DADS State Office policy on focus case reviews. Because the Facility will be changing their current process to reflect the DADS policy and procedure in the near future, the Monitoring Team was unable to review materials to determine the Facility compliance

	hence, the Facility remains not in compliance with Provision L.2, of the Settlement Agreement. The Monitoring Team stresses, however, that the focus case reviews must include a mechanism that assesses the clinician's performance. Provision L3: The Clinical Director informed the Monitoring Team that the Facility had yet to begin developing a process to collect, and analyze data for quality improvement of medical services at the Facility. The Facility expects direction from DADS State Office for direction in the near future. Because there was no evidence to review, the Monitoring Team was unable to request, and review information to determine compliance. For this reason, the Monitoring Team had determined that the Facility remains not in compliance with Provision L.3, of the Settlement Agreement. The Facility must immediately begin developing a process that will collect and analyze clinical data for quality improvement purposes. Provision L4: The Clinical Director informed the Monitoring Team that the Facility had not developed a local policy or procedure for the provision of medical care that was consistent with current, generally accepted professional standard of care, and was awaiting direction from DADS State Office. The Monitoring Team was made aware by the DADs Clinical Coordinator, that DADS continues to work on developing standard of care protocols, and clinical pathways, however, they are not ready for implementation. Given that a process has yet to be developed, and implemented, the Facility remains not in compliance with Provision L.4, of the Settlement Agreement. Compliance will require that appropriate policies and procedures are developed and implemented at the Facility. The Monitoring team will assess efficacy of the process by reviewing practice standards at the Facility.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	In general, the Monitoring Team noted improvements in the follow-up to many consultation reports and abnormal laboratory and other diagnostics that required follow-up. These improvements were noted over the previous two Months, since the hire of a physician who specializes in adult medicine. The Monitoring Team recognizes that it will require additional time for the newly hired physician to complete a comprehensive review of all primary care issues at the Facility. To assess the Facility's ability to provide adequate medical support and services for the Individuals who reside at the Facility, the Monitoring Team conducted a detailed case review that involved direct observation of the individual, comprehensive review of the clinical records, and in some cases, discussion with staff, for Individuals #74, #94, #140, #1, and #72. Following the on-site review of Individuals #74, #94, #140, # 1, and #72, the Monitoring Team determined that the overall management, and coordination of care among disciplines at the Facility did not meet standard of care practice. The Facility did not adequately provide appropriate management for chronic care conditions, such as	Noncompliance

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		diabetes, osteoporosis, abnormal laboratory studies, including chronic low vitamin D, ferritin, and folic acid levels, as well as for potentially serious bowel related conditions. The Monitoring team concluded that the PSP process failed to adequately identify and monitor serious medical conditions, provided inadequate risk assessments, and did not adequately inform staff of serious issues that required monitoring. The following cases represent examples of the Monitoring Team's findings: Individual #94: The Monitoring Team observed this individual at living area 502, on August 22, 2011. The individual was observed to have one-to-one staffing for behavior issues, while undergoing medication changes; The Monitoring Team noted the individual as having a broad based gait while ambulating; at least moderate cervical scoliosis; and reports by staff indicated that the individual would periodically drop to the floor and attempt to hit people. The Following issues were noted by the Monitoring Team upon review of the Individual's clinical record, on August 22, 2011: The Safety Assessment for activities on and around water, dated 05-24-11, indicated that there were no gait issues, and no need for adaptive device for ambulation. There was no comment on aspiration risk. The assessment did note that there was a history of falls and that the supervision level was "routine." The assessment contradicted the Monitoring Team's observation of abnormal gait, level of supervision and known aspiration risk. The Annual Medical Assessment, dated June 8, 2011, was reviewed on August 22, 2011, and noted the following: Mild arthritis change of the hip; a hepatic hemangioma, which was reported to be stable, but required follow-up; and GERD. A Barium swallow test, completed on July 29, 2010, demonstrated an oral phase of "mild pathology, premature loss to valleculae and pyriform. Oral residue reduced AP propulsion, decreased tongue strength and ROM." Subsequent to these findings, the individual's diet was downgraded to a pureed diet. On March 3, 2011, an evaluation was completed for dysphagia, and the results demonstrated "moderate dysphagia." The speech pathologist's comments on dysphagia were not addressed by the physician. There was no noted follow-up to ascertain the etiology of the dysphagia, and dysphagia was not listed on the diagnosis, or problem list. The PT/OT assessment documented on 5/25/10 indicated that the individual had a "moderate right thoraco-lumar scoliosis with flat lumbar spine, and external rotation of the hips, and pronated feet." There was no documentation by the physician commenting on the individual's noticeable gait abnormality or scoliosis. Such orthopedic issues must be assertively managed by the primary care provider, and referred to specialists for evaluation. There was no indication that the primary care provider had evaluated or addressed these important findings. Orthopedic conditions, especially of the hips and	

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		spine, may result in continued degeneration, leading to further disability and injury, such as repeated falls, fractures, and paralysis. A follow-up MRI of the liver was completed on July 5, 2011, that demonstrated a stable hepatic mass, suggestive of a possible atypical hepatic hemangioma, but with other etiologies not excluded. Other smaller stable masses were also noted throughout the liver. The Facility obtained a Gastroenterology consultation to address the hepatic mass on July 14, 2011. The consultant recommended repeat imaging studies in one year and to obtain an alpha fetoprotein level (AFP). The Facility did obtained the AFP, and the results were negative. Importantly, however, the issue of known elevated hepatic enzymes was not addressed. Hepatic enzymes were noted to be rising over a period of many months, without further assessment. The combination of multiple hepatic masses, along with rising hepatic enzymes must be assertively managed. This issue was brought to the attention of the clinical director at the time of this review. An X-ray of abdomen demonstrated constipation, and there was no documented follow-up. The physician assessed the issue of the Individual "throwing himself to the ground." The physician noted that the Individual had calluses on the foot, suggesting that might be the cause. The physician also recommended that the staff should check the individual's shoes, belts, and clothing to ensure that they "don't cause discomfort or pain." There was no indication that the physician performed a physical, and obtained necessary diagnostics to assess the individual's countless falls. The individual had several known orthopedic conditions and other medical conditions that might account for the individual's falling episodes. Through review of the Personal Support Plan (PSP), and addendums to the PSP, the Monitoring Team determined that the Personal Support Team (PST), did not adequately review and address the individual's clinical issues, and the PSP did not clearly identify the necessary supports and services that were required for this individual. Individual #140: The Monitoring Team observed this individual at living area 502, on August 22, 2011. The Monitoring Team noted the individual to be very pleasant, and communicative, while standing in her Merry Walker. A social service assessment dated August 25, 2010, stated that the Individual had over 43 falls since January 2009. The assessment raised concerns over the individual's problem with ambulation. Physical Therapy response was not adequate, and did not offer any meaningful findings or recommendations. The Annual Medical Examination, dated August 22, 2011, was unsigned by the physician. The review of systems and physical	

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		examination noted the abnormal gait, and the individual was diagnosed with an "unsteady gait" and truncal weakness. An MRI of the lumbar spine dated April 4, 2011, demonstrated degenerative disc disease at levels L4-L5, and L5-S1. A neurology consultation for seizure disorder (not the gait issue), commented on the physical exam that the Individual "is wheelchair bound for chronic spastic paraparesis," which is a diagnosis that is not on the individual's problem list. The individual was seen by an orthopedic specialist in 2010, because of her worsening gait problems, and was further referred to a physiatrist to evaluate the gait problem. The Physiatrist evaluated the individual on December 6, 2010, and February 2, 2011, and noted a "shuffling gait with impaired coordination, exaggerated reflexes, hypersensitivity on the left side, and worsening weakness on the right side then the left" and recommendations for an AFO, CT of the head, and MRI of the lumbar spine, and EMG studies, were made. The Facility obtained the MRI of the spine, but there had been no further follow-up, with the exception of the Individual now using a Merry Walker. The Monitoring Team was exceptionally concerned with the overall coordination of care of this individual. The individual is demonstrating signs and symptoms suggestive of a serious degenerative condition, such as a neuromotor or musculoskeletal system disorder. The primary care physician must coordinate the overall care and management of this Individual and ensure that appropriate consultants are involved and that the consultants are acutely aware of the person's condition. It is paramount that consultants understand that the individual had experienced a significant deterioration in function. The primary care physician should have also ensured that the abnormal MRI of the spine was followed-up, in context with the individual's significant functional decline. A chest x-ray, dated August 1, 2011, noted no acute infiltrate, minimal atelectasis and mild cardiomegaly. The primary care physician did not address the cardiomegaly. Cardiomegaly can be a serious condition secondary to many underlying cardiovascular conditions, and may exacerbate over time and result in worsening disability and possibly death. A pelvic ultrasound on January 10, 2011, diagnosed two possible abutting anterior myometrial uterine fibroids. At the time of this review, there had been no follow-up on this issue. Fibroids can manifest in pain and discomfort, which in turn may manifest with behavioral challenges. An ultrasound of the kidneys was obtained on April 4, 2011, that demonstrated bilateral echogenic kidneys "consistent with medical renal disease." Although the diagnosis of "chronic renal impairment" was noted on the problem list, given the findings on ultrasound, there was no meaningful explanation offered as to the etiology or follow-up plan for this issue.	

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		The Monitoring Team determined that the PSP, dated August 25, 2010, did not adequately reflect health care issues or necessary supports and services. Addendum PSP reports dated August 17, 2011, August 8, 2011, and August 2, 2011 all delineate that she has an abnormal gait and resulting injuries; however, the team only focused on level of supervision and adaptive devices and not the root cause of the abnormal gait and/or what is being done for her medically, for this condition. The Monitoring Team determined that the coordination of care, and general management of this individual's health conditions, was not at the level of generally accepted of standard of care practice. Individual #72: The individual was observed at vocational program, and was noted to have a significant abnormal gait, which clearly required support by staff. Vocational staff reported that the individual requires one-to-one staff support when ambulating, and that they were to assist him by holding onto his "lift vest." The Monitoring Team reviewed the Facility's monitoring record for supervision levels. Despite the Vocational staff reporting that the individual requires one-to-one supervision to assist with the gait problem, the report dated August 22, 2011, indicated that the individual required 1:1 supervision for one day, on August 19, 2011, following return from colonoscopy procedures. Living area nursing staff were interviewed and could not inform the Monitoring Team why the individual required one-to-one supervision and why he remained on one-to-one supervision; different staff had different understanding of whether or when one-to-one supervision was required. Furthermore, the PT/OT annual update, dated June 14, 2010, indicated the need for a "gait belt/lift vest," which is to be worn at all times when he is out of bed, and to assist with balance during gait and transfers. The PT/OT assessment was devoid of any physical assessment. Importantly, the individual was seen for a one year follow-up for a history of a "left total hip," on September 28, 2009. The consult report indicated "excellent position of left total hip, all looks well, walking with only mild limp, good ROM without pain," and was to follow-up in one year. The individual was then again seen on September 10, 2010, and recommended "full ambulation and follow-up in one year." As observed by the Monitoring Team, the individual's gait is far from normal. The Monitoring Team had significant concern over the management of this individual's gait issue, including the marked discrepancy of staff understanding and implementation of the individual's level of supervision. Given that there appears to be worsening of the individual's ability to balance and to self ambulate, especially following a hip surgery, assertive clinical follow-up is required, which was not evident by this review. The clinical record indicated that the individual was seen by a gastroenterology in 2007, and was diagnosed with a hyperplastic colon polyp that placed the person at risk for colon cancer, and an internal hemorrhoid. The polyp was removed and the individual	

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		was to return to the Gastroenterologist in two weeks, following the removal of the polyp. The individual did not follow up with the Gastroenterologist until July 26, 2011, and subsequent colonoscopy was completed on August 19, 2011. The colonoscopy report was not available for review. The lack of timely follow-up for the colonoscopy was of serious concern to the Monitoring Team. Furthermore, there was no mention in the clinical record of the medical management for the individual's internal hemorrhoid. Hemorrhoids can be painful and cause discomfort, which could manifest with behavioral challenges. They can also exacerbate and result in internal bleeding and other conditions. The individual's PSP dated June 14, 2011 indicated that the individual had fallen seven times this past year, and rated him at a medium risk for falls. He was also rated at a medium risk for osteoporosis, although he had a diagnosis of osteoporosis. Physical and Nutritional Management was not reviewed per the PSP report. None of the medical issues, including his risk for colon cancer, post colonoscopy, history of osteonecrosis of the hip, and significant abnormal gait was not described. The Monitoring Team was concerned over the risk rating of Medium for both falls and osteoporosis. Given the reported histories, the individual is at high risk for both falls and osteoporosis. It was of significant concern that the PSP did not address the serious medical conditions, such as risk for colon cancer, post colonoscopy, and history of osteonecrosis of the hip. Individual #1: The Monitoring Team while at the Facility reviewed the clinical record of Individual #1. The individual was noted to have diabetes mellitus, and was treated with metformin. The individual's glucose management was excellent, as noted per A1C values of 4.7. The physical exam completed by the physician noted "a few sores on the lower extremities, but they are dry." The Individual did see a dermatologist in 2009 for a similar issue. The medical plan, dated July 25, 2011, did not address the lower extremity lesions, or recommend the need for further evaluation. Evaluation for microalbumin was not completed, as should be done for individuals with diabetes. There was no evaluation reported of a foot assessment, which should be noted on all diabetics, individuals with diabetes, especially when there are chronic wounds on the lower extremities. In addition, the PSP determined a low risk level for diabetes for this individual, when the individual actually had a diagnosis and was being treated for diabetes. For these reasons, the Monitoring Team determined that the overall management of this chronic condition was inadequate. The Diagnosis of constipation was noted on the Annual Medical Assessment, dated July 25, 2011, and the Medical Plan indicated "monitor bowel habits as she has a history of redundant colon" and "make sure she gets her Benefiber, three times a day more liquids like water as a laxative." There was no evidence noted that confirmed that fluid intake was monitored or reviewed. An abdominal X-ray was obtained on July 27, 2011 for	

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		abdominal pain, which demonstrated a non-specific bowel gas pattern, and suggested possible ileus, and recommended CT follow-up. The CT of the abdomen demonstrated redundant colon with extensive amount of stool throughout the colon. The PST reviewed the CT results with the physician on August 11, 2011, and determined that the results were "normal." The individual was provided two Fleets enemas, and a follow-up abdominal x-ray was obtained on August 12, 2011, that was read as unremarkable, indicating that the extensive stool had cleared with treatment. Importantly, the individual had a prior colonoscopy that documented a redundant and tortuous bowel in the past. The Monitoring Team noted several issues of concern regarding the individual's bowel issues. Although a redundant bowel, in itself, is not unusual, in the context of a person with diabetic diabetes with recurrent constipation and reports of abdominal discomfort, the issue becomes magnified, and the individual should be at least considered high risk for serious and potentially lethal consequences, such as bowel obstruction and perforation. Also, fiber supplementation is considered a treatment for most cases of constipation; however, one must consider all of the ramifications of supplemental fiber (Benefiber), when the person may not be provided adequate fluids; when there are significant anatomical and physiological conditions, such as a tortuous bowel; and when possible gastroparesis exists, that may decrease colon transit time. The Monitoring Team had concerns over the PSPs risk rating of a "medium risk" for gastrointestinal problems. Based on this review, the Monitoring Team determined that the individual was at a serious risk for bowel related issues, and required more assertive monitoring and treatment, such as daily reports on bowel movements, periodic abdominal assessments, monitoring of fluid intake, consideration of a long-term strategy for treatment, such as alternating anticonstipation medications, consideration for possible surgical reduction of the colon, if necessary, and additional consultation with a gastroenterologist. The Monitoring Team met and discussed the individual's clinical issues with direct care staff at the living area. The direct care staff person did not know to monitor fluid intake, to increase toileting or assess bowel movements, or the need to increase fluid intake. The staff person did recognize that the individual had serious problems with her bowels. Following its overall review of the clinical management of this Individual, the Monitoring Team determined that there was lack of coordinated effort to effectively monitor and treat the individual's underlying chronic care issues, and that the PSP did not adequately address the Individuals clinical conditions, and necessary supports and services. Individual #74: The individual had a known diagnosis of chronic constipation, tonic-clonic seizure disorder, an anal fissure and post fissurectomy, and low folic acid and ferritin levels. Importantly, the individual was reported as having increase seizure activity, which may have been contributed to medication change, and findings of	

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		osteopenia on a recent DEXA scan. During a PST meeting, staff were concerned about an increased frequency of falls secondary to his seizure exacerbation, but they did not change his risk rating for seizure activity from low to high. The team also did not consider the individual's newly diagnosed osteopenia, in context of the number of falls the Individual was experiencing, and did not increase his risk level for fractures. Most important, direct care staff were not advised of the increased seizure risk and potential fracture risk, and how to best to support the person at the Facility and when on outings. The Team was considering increasing his activities near water; however, they did not consider reviewing the water risk assessment, especially since there was recent exacerbation of seizure activity. There was no medical assessment to determine the underlying etiology of the known low ferritin level. This condition may be secondary to chronic, albeit subtle, blood loss. There was no assessment to determine the underlying cause of low folic acid level, which could be secondary to a malabsorption, or other conditions. There was no meaningful assessment to determine the etiology of the individual's low vitamin D levels. Importantly, there was not medical assessment to determine the underlying etiology of the individual's osteopenia. The diagnosis of osteopenia and osteoporosis, especially in a young male, must always be evaluated for serious and potentially reversible causes of the low bone density, such as hypogonadism. Specific to improvements, the Monitoring team noted improved documentation of acute issues, and follow-up to many outstanding consultations and diagnostics, following its review of the active clinical record for Individuals: Individuals #74, #94, #140, #1, and #72 <u>Mock Code Drills and Emergency Response Systems</u> Findings and recommendations related to mock code drills and emergency response systems are discussed with regard to Section M.1 of the Settlement Agreement. In general, improvements had been made in the process of drills and in the availability of equipment. Some improvement still remain to be made., including greater participation by physicians. Therefore, the Monitoring Team determined that the Facility remains not in compliance with Provision L.1, of the Settlement Agreement.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and	The Facility had not adopted the new DADS focus case review process. The Clinical Director informed the Monitoring Team that the Facility will be adopting the new process in the near future.	Noncompliance

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	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.	Given the Facility's acknowledgement that they will be changing their process, the Monitoring Because the Facility had not been provided an external review through the DADS external review process, Team was unable to assess external review audits. The Monitoring Team was made aware of the DADS policy for focus case reviews, and had commented in the past, on previous reports, that actual clinical performance reviews of the practicing provider must be incorporated into the new process.	
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.	The Clinical Director informed the Monitoring Team that it had yet to begin developing a process to collect, and analyze data for quality improvement of medical services at the Facility. The Facility expects direction from DADS State Office for direction in the near future. The POI reported the Facility had implemented in July 2011 an audit tool for Medical Services. Results from the first month audit were not provided to the Monitoring Team. Because there was no evidence to review, the Monitoring Team was unable to request, and review information to determine compliance. For this reason, the Monitoring Team had determined that the Facility remains not in compliance with Provision L.3, of the Settlement Agreement.	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 compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Clinical Director informed the Monitoring Team that the Facility had not developed a local policy or procedure for the provision of medical care that is consistent with current, generally accepted professional standard of care, and was awaiting direction from DADS State Office. The Monitoring Team was made aware by the DADS Clinical Coordinator, that DADS continues to work on developing standard of care protocols, and clinical pathways; however, they are not ready for implementation. Given that a process has yet to be developed, and implemented, the Facility remains not in compliance with Provision L.4, of the Settlement Agreement.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:
1. The Facility must enhance its ability to manage chronic care issues, such as diabetes, chronic constipation, and osteoporosis.

2. The Facility must develop a mechanism that ensures the efficacious provision of medical services. Developing communication forms, streamline meetings, ensuring a process to report and triage both acute and chronic conditions, establishing a mechanism to ensure that a comprehensive physical examination can be completed, ensure that allied clinical professionals perform their evaluations timely and appropriately (e.g., physical therapists must perform and document a comprehensive physical assessment and provide clear and rational recommendations to the physician), and ensure that all clinical information is documented, will help enhance the delivery of medical services.
3. There must be a comprehensive medical plan that is well delineated in the active record for each clinical condition.
4. All abnormal diagnostics, and all consultation reports must be reviewed, and followed-up on. Such action must be well documented.
5. Develop a mechanism to ensure that both acute and chronic care issues are appropriately triaged by the physician and followed by the physician until full resolution.
6. All chronic and recurring conditions must be evaluated to determine the underlying etiology of such condition. This is especially important for functional status changes, dysphagia, orthopedic, neuromotor, changes in bowel function, and osteoporosis, among others
7. The PSP must adequately reflect all clinical issues related to the individual, and PST members including direct care staff must be aware of what conditions require monitoring, and what supports and services are necessary to address clinical concerns.
8. Develop and implement a mechanism that ensures the collection of clinical data, perform trends analysis, initiates outcome strategies, initiate corrective measures when necessary, and monitor corrective measures to ensure that remedies are achieved.

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement, 8/9/2011 2. RGSC Nursing Services Manual 3. RGSC Standard Operating Procedure, NR 400-01, Nursing Services, Date Revised: 2/1011 4. RGSC Standard Operating Procedure, NR 200-32, Competency Based Training Curriculum-Agency/Contract Nurses, Date Established: 11/2011 5. RGSC Standard Operating Procedure, ICF-MR 100 18, Medical Emergency Response, Date Established: 9/3/2010 6. RGSC Standard Operating Procedure, NR 100-05, Nursing Services Staffing Plan, Date Established: 10/25/2009 (Next review/revision date due 3/2011 – not updated) 7. RGSC Standard Operating Procedure, EC 401-01, Infection Control Plan, Date Revised: 7/2011 8. RGSC Standard Operating Procedure, EC 403-05, Hand Hygiene/Hand Washing Frequency, Date Revised: 7/2011 9. RGSC Standard Operating Procedure, EC 404-05, Report of Employee Infections, Date Revised: 6/2011 10. RGSC Standard Operating Procedure MR 400-02, At Risk Individuals. Revised: 2/2011 11. RGSC Standard Operating Procedure, NR 400-08, Medication Administration Guidelines, Date Established: 4/2011 12. RGSC Standard Operating Procedure, NR 200-24, Medication Administration: Rules/Responsibilities, Date Revised: 3/2011 13. RGSC Standard Operating Procedure, NR 400-07, Medication Administration Record, Date Revised: 2/2011 14. RGSC Standard Operating Procedure, NR 100-59, Medication Administration: Rules/Responsibilities, Date Established: 8/1987, no revision date 15. RGSC Standard Operating Procedure, NR 400-12, Medication Error Policy, Date Revised : 2/2011 16. RGSC Standard Operating Procedure PH100-017-09, Medication Error Policy, Date Revised: 3/2011 17. RGSC Standard Operating Procedure, NR 400-02, Seizure Management, Date Revised 2/2011 18. Texas Health and Human Services Commission, Infection Control Training Manual, Dated: 9/2003 19. RGSC Nursing Department Organizational Chart, 6/2/2011 20. RGSC Intermediate Care Facility FY-2011, Nursing Staffing Plan (number of allocated positions) 21. RGSC Nursing Services Activity Summary FY-2011, Minimum Staffing Levels, all shifts 22. RGSC ICF-MR Nursing Schedule for El Paisano and La Paloma, 1/2011 through 6/2011 23. RGSC ICF-MR Nursing Services – Employee Staffing Analysis for El Paisano and La Paloma, 1/2011 through 6/2011 24. RGSC Nursing Meeting Minutes, 1/2011 through 5/2011 25. RGSC Mock Medical Emergency Drill – Completed Drill Sheets and Monthly/Quarterly Schedules for past six months 26. RGSC Memo, Subject: Recommendations for Improvements Regarding the Mock Drill Internal Process, Data Analysis, and Follow-up, from ICF-MR Director, 8/25/2011 27. RGSC List for Locations and Information of Automated External Defibrillators (AEDs) 28. RGSC Emergency Equipment Checklists for past three months

	29. RGSC Competency Training and Development Report for Emergency Response, Dated: 7/18/2011 30. RGSC Safety/Risk Management/Infection Control Committee Meeting Minutes for the past six months 31. RGSC Infection Reports for the past six months 32. RGSC Healthcare Associated Infection Rate Reports for the First, Second, and Third Quarter, 2011 33. RGSC Comprehensive Preventative Health Database, Updated: 8/24/2011 34. RGSC Memorandum to ICF Nursing and Direct Care Managers and Supervisors, Regarding: Joint Commission Survey and POI Settlement Agreement – Hand Hygiene Compliance, Dated: 8/12/2011 35. World Health Organization (WHO) Patient Safety Observation Form, Date Revised: 8/2009 36. WHO Your 5 Moments for Hand Hygiene Poster 37. Centers for Disease Control (CDC), Hand Hygiene is the #1 way to prevent the spread of infections, poster, no date 38. RGSC Hand Hygiene Quiz Form 39. RGSC Monthly Hand Hygiene Trending and Analysis and Environmental Surveillance Reports for the past year 40. RGSC Quality Enhancement: Section M and Q Monitoring Tools' Reports for the Third and Forth Quarters FY2011 41. RGSC Personal Support Plan Schedule for Annual and Quarterly Nursing Assessments 42. RGSC Nursing Services - Training/Tracking Database, 3/2011 through 7/2011 43. RGSC Nursing Department Training Curriculum for Direct Care Professionals on Signs and Symptoms of Common Illnesses and Signed Training Rosters 44. RGSC Medication Error Process for Investigating, Tracking, Trending and Plans of Correction 45. RGSC Medication Error Events and Investigations 3/2011 through 8/2011 (including last 10 Medication Errors) 46. RGSC Pharmacy and Therapeutic Sub-Committee Meeting Minutes, March 2, 2011 and June 29, 2011 47. RGSC Medication Administration Observation Schedule 48. RGSC True Track Blood Glucose Monitoring System Daily Quality Control Records for El Paisano and La Paloma for the past six months 49. RGSC Community Living Discharge Plan (CLDP) Policy and Procedures, no date 50. RGSC CLDP for Individual #10, Date: 10/27/2010 51. RGSC E-mail from Lorraine Hinrichs, ICF-MR Director Re: DOJ Recommendations from PNMT and Walk-through, 8/22/2011 at 6:13 p.m. 52. RGLC Common Signs and Symptoms of Acute Illnesses and Injuries Curriculum 53. Texas Department of Family and Protective Services, Adult Protective Services Referral Form, Case ID: 38689838, 3/1/2011 54. RGSC Medical and Dental Appointment Database 55. Records Reviewed for Individuals: #31, #27, #51, #4, #85, #139, #96, #66, #140, #86, #23, #47, #126, #80, #108, #69, #118, #61, #82, #2, #75, #79, #54, #98, #11, #1, #97, #107, #10, #19, #12, #76, #40, #63, #115, #118, and #134 **People Interviewed:** 1. Yolanda Gonzalez, RN Chief Nurse Executive 2. Mary Doris Matabalan, RN, Nurse Operating Officer/Hospital Liaison 3. Jessica Juarez, RN, Quality Enhancement Nurse

	4. Marcy Valdez, RN, Unit Nurse Manager 5. Albert Weaver, RN, Unit Nurse Manager 6. Robin Martin, RN, Infection Control Preventionist/Nurse Educator 7. Lorraine Hinrichs, ICF-MR Director 8. Ricky Zuniga, Interim Vocational Manager 9. Numerous Staff Nurses and Direct Care Professionals **Meeting Attended/Observations:** 1. At risk Meeting Individual #80 – 8/22/2011 and Individual #40 – 8/24/2011 2. Multiple Tours of El Paisano and La Paloma 3. Medication Administration Observations in La Paloma and El Paisano, afternoon of 8/25/11
	Facility Self-Assessment: The Facility's Plan of Improvement, updated 8/9/2011, provided comments and status for Sections M.1 through M.6 of the Settlement Agreement. The Facility indicated it not in compliance with Provisions M.1 through M.6. This was consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. The Facility's Self-Assessment information as reported was inadequate to determine the progress made toward compliance for all provisions; most information was repeated from the last two reviews. The information contained for the various provisions did not always relate to the Settlement Agreement requirements for the specific provisions. There were no relevant observable or measureable data contained in the self-assessment data that indicated how those activities were moving the Facility toward compliance within the respective provisions. There was no clear sequential framework or timelines established to identify how they expected to reach and maintain compliance. The Facility's POI contained a summary of action plans on which they were working to achieve compliance. The action plans were not specific and failed to consistently relate to the requirements of the provisions in the Settlement Agreement. There was no identification of data that would be used to demonstrate compliance. The Facility needs to ensure that the activities and action steps included in the POI reflect only the requirements set forth in the Settlement Agreement for that specific provision. The information included should only include activities and actions steps that have been completed since the last review or that are in process from previous reviews. Through a review of the Presentation Book for Section M, record reviews, interviews, and observations the Monitoring Team was able to validate that some of the activities listed in the Facility's Self-Assessment were carried out and showed improvement in moving the Facility toward compliance for some of the provisions. These activities and improvements were discussed in the Monitor's Assessment and throughout the report.
	Summary of Monitor's Assessment: **Provision M.1:** This provision was determined not to be in compliance. This provision contained a number of requirements that addressed various areas of compliance. These include: staffing, availability of pertinent medical records, assessment and documentation of individuals' acute changes in status, infection

	control, medical emergency response systems, and quality enhancement efforts. In order to meet compliance with this provision all these requirements of the provision must be found in compliance. Although compliance was not met for this provision, since the last review some improvements were made. Improvements were noted in the following areas: • Assessment and documentation of individuals' acute changes in status, and more consistent use of the SOAP format for documentation. • The NOO/Hospital Liaison consistently visits individuals in the hospital and reported findings in the Integrated Progress Notes, as well as in the shared drive, to keep the physician and relevant team members apprised of individuals' status. • The nursing staff were improving the assessment of pain and documenting individuals' response to per needed (PRN) medication. • The 10-6 shift RN was completing 24-hour chart checks to ensure Physician Order's were transcribed. • The Medical and Dental Appointment Database continued to improve by adding the reason for missed appointments in order to track and trend missed appointments. The data summary, March through July, 2011, for 24 Hour Chart Checks and Scheduled Appointments found an overall compliance of 88% and 86% respectively. The Facility reported the audits and their outcomes had helped the entire Facility, not only the department for which the incident of missed orders had been prevented, but also in ensuring that appointments were made in a timely manner, not missed and/or were rescheduled when indicated. This assured that individuals received their necessary care. • The Infection Control Preventionist Nurse had completed 100% of preventative health and immunization records and had a compliance rate of 97.86%. • The emergency response system demonstrated improvement by placing emergency equipment in the Vocational Services area for ready access. There was evidence that Mock Medical Emergency Drills were scheduled and completed according to policy. There was documented evidence when drills were failed that "on the spot" corrective action was taken and if that was not effective individuals were sent for re-training. While improvements were found toward meeting compliance, there remained the need for continued improvements in all requirements of this provision, particularly in areas listed below as well as those which are identified in the report and in the recommendations: • The Nursing quality assurance system was still evolving. Few of the Nursing Care Monitoring Tools had been completed. There was inadequate data available to determine compliance. A major concern was lack of adequate full-time nursing positions. • The Infection Control Preventionist Nurse/Nurse Educator was no longer also serving as the Nurse Educator. The Nurse Manager for La Paloma was assigned 20 hours per week as the Physical and Nutritional Nurse while continuing full-time responsibilities as a Nurse Manager. The Nurse Case Managers also served as staff nurses, taking time away from attending to case management responsibilities. In order to resolve the problem contract agency LVNs had been hired to free up time for the Nurse Case Managers to complete their case management duties.

	Provision M.2: This provision was determined not to be in compliance. Since the last review some improvement was found in the Annual and Quarterly Comprehensive Nursing Assessments in Sections I through X. The Nurse Case Managers were still struggling with how to adequately summarize individuals' nursing problems/diagnoses to describe individuals' progress toward established goals and objectives. The Nurse Case Managers need additional training on how to summarize nursing problems/diagnoses to adequately assess individuals' progress toward meeting their established goals and objectives and to assess the effectiveness of their plans of care. **Provision M.3:** This provision was determined not to be in compliance. Since the last review the nursing staff were providing training to the direct care professionals on care plans as opposed to giving the care plans to the home manager or supervisors to provide the training. The nursing staff had developed special instruction sheets derived from care plans to put in the Me Books for the direct care staff to use as reference. Review of 28 individual's HMPs/ACPs showed that the nursing staff had developed, implemented, and trained direct care professionals on the special instruction sheets for each of the care plans. At the time of the review it was discovered that the special instruction sheets had been removed from the Me Books because they did not have a record number. The ICF-MR Director was contacted and she was in the process of resolving the problem to get record numbers for the special instruction sheets so they could be replaced in the Me Books. The Health Maintenance Plans and Acute Care Plans failed to be individualized to meet individuals' unique needs. **Provision M.4:** This provision was determined not to be in compliance. The Nursing Department continued to maintain an excellent Nursing Training and Tracking Database, which included the names of the topics taught, number of nurses trained on each topic, percentage of total nurses that received training on each topic, and the projected completion date for each topic. According to the CNE the staff had not been trained on all of the State nursing policies, procedures, processes, and protocols. Neither had training begun using the Nursing Education Handbook Manual. The loss of the Nurse Educator had made it difficult for the Nurse Managers and Nurse Case Managers to complete all of the training needed due to their other responsibilities. The Nurse Educator position had been posted and was being actively recruited. **Provision M.5:** This provision was determined not to be in compliance. Since the last review, the nursing staff continued to complete At Risk Screening Assessments in conjunction with the individual's primary care physician. The PST continued to primarily rate risk levels according to the guidelines. The nursing staff needs to exercise clinical judgment and critical thinking in addition to the guidelines when rating risk levels. The AT Risk Screening process was still evolving. **Provision M.6:** This provision was determined not to be in compliance. The timeliness of correcting and investigating medication errors had improved. The Medication Administration Error Database was continuing to be refined. Medication error data had just recently been separated from the other RGSC Facilities and were beginning to be entered into the database. Since the last review a schedule for Medication Administration Observation had been developed and implemented. There was no documentation supplied for review that validated that the scheduled

	observations had occurred or that observation data were analyzed, trended, and plans of correction developed, implemented, and followed through to resolution. During medication administration observations completed on site, several problems were identified: The direct care professionals were not assisting the nursing staff during medication passes. There remained a lack of privacy for individuals when receiving medications. The problems continued with the use of the MediMar electronic record system and the use of paper Medication Administration Records. This caused an increase in time to pass medications as well as the risk for making medication errors. The Monitoring Team observed poor medication practices being implemented by the nurse administering medications. Individuals' PNMPs were not reviewed and followed.

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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>Staffing</u> At the time of the review the Facility was providing services to 71 individuals. Since the last review general improvement was found in the organization and structure of the Nursing Department. The Nursing Department had hired an additional Nurse Manager, which provided a Nurse Manager for both La Paloma and El Paisano. A Nurse Case Manager system was fully implemented with four Nurse Case Managers. Each Nurse Case Manager had a caseload ranging from 17 to 19 individuals based on levels of acuity. Nurse Case Managers were often required to provide staffing nursing coverage; as result attention was taken away from fulfilling their case management responsibilities. In order to resolve this problem, additional agency nurses were used to free-up time for the Nurse Case Managers to attend to their case management responsibilities. At the time of the review eight Registered Nurses (RNs) and eight Licensed Vocational Nurses (LVNs) positions were filled, with three RN and one LVN vacancies. The Infection Control Preventionist Nurse/Nurse Educator had assumed the full-time responsibility for Infection Control for both the ICF-MR Program and the Mental Health Services, leaving the Nursing Department without a Nurse Educator. The Nurse Educator position was posted and recruitment was in process. The Nurse Manager for La Paloma was assigned 20 hours a week to serve as the Physical and Nutritional Management Nurse. In order for these positions to fulfill the roles and responsibilities inherent in each position, the Facility should consider a full-time position for both the Nurse Manager and the Physical and Nutritional Management Nurse. The Nursing Services Staffing Plan established a minimum staffing ratio of one RN and one LVN for each shift for both La Paloma and El Paisano. A review of staffing analysis for the past six months indicated that the established staff nurses' ratios to individuals were consistently met. Nursing shortages were offset through the use of Nurse Managers, Nurses Case Managers, overtime, and use of agency nurses. This requirement of the provision was not found in compliance. In order to meet	Noncompliance

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		compliance with this requirement the positive practices identified in the report must be maintained and improvements made in other practices. The Nursing Department should make the following improvements: • Ensure adequate full-time staff nursing positions to provide coverage to eliminate the need to use Nurse Managers, Nurse Case Managers, and agency nurses to make-up the shortage in staffing. • The Nurse Educator position should be filled as soon as possible. • The Nurse Manager position should not also double as a Physical and Nutritional Management Nurse because the role and responsibilities inherent in each position requires full-time attention. <u>Availability of Pertinent Medical Records</u> As was found in past reviews, the Integrated Progress Notes contained in the Client Work Station (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. It was not functionally practical to access for a chronological review 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 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. The potential for vital health related data to be overlooked in making critical clinical decisions continued to be a problem. Refer to Provision M.6 regarding the removal of the special instruction sheets for training the direct care professionals on healthcare plans from the Me Books. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Since the last review, some progress had been made in this requirement of the provision. There was evidence of progressive improvement in the use of the SOAP method of charting in the Integrated Progress Notes. The response and effectiveness to pain medication was better assessed and documented. Communication with the transferring emergency room and hospital personnel improved. There was evidence that 24-hour chart checks on Physician's Orders were being completed. It was positive to find, at this review, no missing transcription orders. The Nursing Department continued to refine and improve the Medical and Dental Appointment Database. The reason appointments were missed was added to the database for tracking, analyzing, trending, and developing corrective action plans. Consistent with previous findings, there continued to be significant problems regarding	

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		the nurses' competency in assessment and documentation. Ten clinical records (Individuals #11, #54, #118, #27, #126, #5, #108, #47, #115, and #40) were reviewed for compliance with the Management of Acute Illness and Injury Procedures, Nursing Documentation Guidelines, and for evidence of integrated services. Problematic trends identified included the following: • Due to the lack of documentation it was difficult to determine when changes in health status initially occurred. • A lack of complete and appropriate nursing assessments in individuals response to presenting signs and symptoms of changes in status; and/or changes in vital signs and oxygen saturation measurements. A lack of consistent lung and/or bowel sound assessments for respiratory and gastrointestinal issues. • A lack of follow-up from issues noted in previous nurses' progress notes. • A lack of specific description of physical appearance, size, and location of skin rashes, injuries and/or bruises. • Lack of documentation regarding activity tolerance for activities during the day for individuals' experiencing or recovering from an acute illness or injury. • Inadequate documentation of the administration and follow-up response of PRNs (as needed medications). • A lack of mental status assessments documented during status changes and/or specific descriptions when individuals were engaging in maladaptive behaviors. • Significant gaps in documentation when the nurses' notes stated, "will continue to monitor." The nurses consistently failed to state what would be monitored and the frequency of the monitoring. • Physicians were not consistently notified in a timely of individuals' changes in status. • The method temperatures were taken was rarely documented. • Lack of documentation that there was communication with the PNMT regarding changes in status for individuals at risk of aspiration/choking, or skin breakdown, or having frequent falls or other related PNMP issues. • Lack of notification/referral to the Infection Control Preventionist Nurse when contagious disease outbreaks occurred. • Lack of analysis of contributing problematic issues affecting changes in status. • Lack of adequate documentation regarding individuals' assessment and status at the time of transfer to the emergency room or hospital. • Lack of consistent documentation regarding nurse-to-nurse communication with the transferring emergency room or hospital. • Lack of regular follow-up for symptoms related to reasons for the emergency room or hospital. • Inconsistently developed and implemented Acute Care Plans for acute changes in status. • Annual and Quarterly Comprehensive Nursing Assessment were not revised to	

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		reflect significant changes in status or new problems until the next assessments were completed. • Lack of consistent updated Health Maintenance Plans (HMPs) to reflect changes in status or new interventions. • Lack of consistent documentation in the Integrated Progress Notes that HMPs and/or Acute Care Plans (ACPs) were initiated. • Lack of adherence to Pre-treatment and Post-sedation Assessment Protocols. • Lack of documentation through to resolution for acute changes in status. • Occasionally inappropriate and unapproved abbreviations were used. • Late entries were frequently documented in the progress notes. Some of the deficits in nurses' clinical competency to provide adequate nursing care for acute conditions, identified above, were validated in review of clinical records of Individuals #54 and #11 for the past six months. • Individual #54: The nurse documented in the Integrated Progress Note on 4/12/11 at 6:55 p.m., that Individual #54 had emesis and 50cc's of red liquid was noted on the floor in her room. Vital signs were taken and appropriate initial care provided. The nurse did not complete respiratory and abdominal assessments. Neither were oxygen saturation levels assessed. The nurse did not notify the RN or the physician of the episode of emesis. Similar events, with similar nurse actions, occurred on 4/13/11 at 1:30 a.m. and 4/13/11 at 5:35 a.m. At 7:55 a.m., Individual #54 had another episode of emesis that contained food particles. Her temperature at that time was reported as 102.6. The RN was made aware of Individual #54's condition and the physician was notified, who ordered individual #54 sent to hospital for evaluation. Before leaving for the hospital the nurse completed a comprehensive physical assessment. At 8:30 a.m., Individual #54 was transported and admitted to the hospital where she was diagnosed and treated for partial small bowel obstruction and aspiration pneumonia. She was discharged on 4/21/11. Upon return home there was documentation the RN completed a complete physical assessment. The nurses monitored Individual 54's health status at least daily on the 6-2 and 2-10 shifts until antibiotic therapy was completed on 4/26/11. However, respiratory and bowel assessments and oxygen saturation levels were not consistently monitored. There was no documented evidence that the nursing staff collaborated with the Physical and Nutritional Management Team to develop a plan of care to prevent the reoccurrence of aspiration pneumonia. There was no documentation in the Integrated Progress notes that that an Acute Care Plan was developed and implemented for aspiration and bowel obstruction. There was no documentation in the Personal Support Plan Addendum of a special called meeting for the team to review Individual #54's change in status and to complete a new risk screening assessment. The unit nurse should have notified the RN and physician at	

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		the onset of Individual #54's vomiting to ensure that prompt medical intervention was initiated. It was positive to find documentation in the Integrated Progress Notes that the Hospital Liaison Nurse kept in daily contact, either by phone or visit with the hospital personnel. The Hospital Liaison Nurse kept the team and guardian informed of Individual #54's progress while hospitalized through telephone calls and the shared drive. • Individual #11 was diagnosed and treated multiple times with an antibiotic for tinea pedis (Athlete's foot), e.g., 2/23/11, 4/20/11, and 8/17/11. There were inadequate nursing assessments regarding his response to treatment and follow-through to resolution. There was evidence that an Acute Care Plan had been implemented on 2/3/11 for this condition. The Acute Care Plan was updated for the reoccurrence of tinea pedis on 4/ 20/11 but was not updated for the reoccurrence on 8/17/11. There was not documentation in the Integrated Progress Notes that the Acute Care Plans were initiated. There was no documentation indicating that the Infection Control Preventionist Nurse had been notified of Individual #11 repeated tinea pedis infections. Tinea pedis is a highly contagious infection and needed to be investigated by the Infection Control Preventionist Nurses to assess hygiene practices and environmental sanitation; and to take corrective action to prevent Individual #11's repeated infections and the spread of infection to other individuals. According to the last two quarters Infection Reports, both units consistently had tinea pedis cases reported. Individual #11 was diagnosed and treated with antibiotics for sinusitis on 3/1/11. He was not assessed and followed according to the Acute Illness and Injury Protocol, which required nursing assessments to be completed on every shift for three days and thereafter until the problem was resolved. Integrated Progress Notes were found on 3/1/11 stating that Individual #11 was treated with Augmentin for an upper respiratory infection (URI). The next entry on 3/3/11 stated, "continues on antibiotic." The note failed to state what the antibiotics were for or the response to treatment. The next entry on 3/13/11, stated Individual #11 had finished the antibiotic treatment and had no nasal drainage. An Acute Care Plan for Sinusitis was initiated on 3/1/11, but the date of resolution was not documented on the care plan. On 3/3/11 Individual #11 was sent to the Urologist to evaluate urinary retention. He was diagnosed with urinary retention secondary to outlet obstruction and medication prescribed to relieve bladder distention. He was continuing to be followed by the Urologist. A Urinary Incontinence HMP that included a bowel and bladder training program was initiated on 3/4/11, and reviewed on 4/17/11 and 7/23/11. The bladder and bowel training plan called for the direct care professionals to take Individual #11 to the bathroom every two hours for toileting. Review of the Integrated Progress Notes over the past six months failed to document	

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		effectiveness of these plans or report episode of urinary incontinence. The PSP on 4/26/11 rated Individual #11's risk for Urinary Tract Infections (UTIs) low in spite of a long-standing history and diagnosis of urinary retention. Although he did not have a history of UTIs, the fact that chronic urinary retention has the potential to cause UTIs, bladder damage due to prolonged overstretching of the muscles, and chronic kidney damage. The PST should have increased his level of risk to at least medium, if not high. On 5/10/11 the PSPA met to discuss Individual #11's urology consult of 3/3/11. It was of concern that it took the PST two months after the urology consultation for the team to meet and discuss the findings and recommendations from the urologist. The members who attended the meeting included a LVN, PNAIII, Psych Assistant, and QMRP. The physician did not attend the team meeting. If residual urines remained high after the medication, the urologist recommended the use of a Foley catheter or intermittent catheterization. The team reported there had been no evidence of residuals and catheterization had not been necessary. Review of the record did not find documentation that he had been checked for residual urine. Therefore, it was puzzling how the team could have known there was no problem with residual urines. It was doubtful that the team members present at the meeting were qualified to make medical decisions regarding the urologist recommendations. The physician should have been present and part of the decision making process. Although Individual #11 had a bladder and bowel training program, the program was not included as a service plan objective. The PSPA minutes 5/18/11 through 8/3/11 continued to report Individual #11's problems with incontinency of urine. On 5/18/11 the team recommended and approved the use of adult briefs. The 6/10/11 PSPA minutes indicated he was happier with the use of adult briefs. There were continuing reports that he tried to urinate in the restroom but many times could not and would urinate in the adult briefs. The 7/27/11 PSPA minutes reported that his maladaptive behaviors which were thought to be attributed to the use of adult briefs and the start of Lithium had decreased. However, the physician ordered the adult briefs discontinued to establish a baseline to assess the effectiveness of the medication used to decrease urinary retention. The 8/3/11, PSPA minutes reported Individual #11 was without adult briefs and had continuous urinary incontinence; and as a result he was out of shoes, underwear, and clothing. He was no longer going to vocational services or on outings. It was reported that he drinks a lot of water. The staff reported that in morning he had to get up to urinate as many as seven times in a four hour period. The team recommended the re-instatement of adult briefs to increase his quality of life. On 8/4/11, the physician ordered adult briefs.	

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		Individual #11's problem with urinary incontinence and retention was identified and reported at the last compliance review. It was evident that he was followed by the urologist, receiving medication for urinary retention, had a HMP for Urinary Incontinence, which included a bladder and bowel training program, and the PST met often to discuss his condition. However, it was disconcerting to find that little improvement had been made over the past six months in managing Individual #11's care and the team appeared to lack an understanding of the medical and psychological ramifications and/or impact that the urinary incontinence and retention had on Individual #11's overall health and well being. The team needs to understand the medical risks associated with urinary retention, as mentioned above. Individual #11 likes to look good and to socialize; when his clothes are wet and dirty he does not like to go to vocational services and to socialize. Although he is taken to the bathroom every two hours, he may not always be able to urinate; and then may incontinently urinate afterward. His inability to urinate is not voluntary or a maladaptive behavior, it is a medical condition that he cannot control. Urinating after being taken to bathroom is usually an involuntary response to bladder overflow. A distended bladder that cannot be relieved can be very uncomfortable and/or painful and may precipitate the maladaptive behaviors. As was suggested at the last review, the team should collect data to determine if the maladaptive behaviors correlate with urinary distention and should consider these data as part of a functional assessment of the target maladaptive behavior. The Facility had procured a bladder scanner and it should be used in collecting data. The team needs to continue to explore options to improve Individual #11's medical condition, reduce the risk of maladaptive behaviors, and improve his quality of life. It was positive to find that the CNE, NOO, and unit nurse responded promptly, assessed and managed Individual #40's seizure activity he experience during the At Risk Screening meeting on 8/24/11 at 4:00 p.m., Individual #40 was sitting in a chair when his eyes began rolling upward and was unresponsive when his name was called. The physician sent Individual #40 to the emergency room for evaluation and was subsequently admitted with a diagnosis of generalized/focal seizures. The NOO/Hospital Liaison Nurse and Nurse Manager remained in contact with the hospital regarding Individual #40's health status through phone calls and visits to the hospital. The relevant team members were kept apprised of his health status. Individual #40 continued in the hospital for evaluation at the time the compliance review was over on 8/26/11. Although there had been some improvements made, assessment of acute changes in status was not done in a manner that meets current, generally accepted standards and would bring this provision into compliance. In order to meet compliance with this provision, the positive practices identified in the report must be maintained and	

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		improvements made in other practices. The Nursing Department should make the following improvements: • Ensure that the nursing staff are competency-based re-trained on Management of Acute Illness and Injury Procedures Nursing Documentation Guidelines, and Pre-treatment and Post-sedation Assessment Protocols. • Ensure collaboration with other disciplines in order to provide integrated services. • Ensure that the nursing staff notify the Infection Control Preventionist Nurse of all infectious and communicable diseases. • Ensure nursing staff document what will continue to be monitor, by whom, and the frequency of the monitoring. <u>Infection Control</u> It was positive to find since the last review, that the Infection Control Preventionist (ICP) Nurse had completed a 100% review of individuals' records for immunization and preventative healthcare screenings. The up to date Comprehensive Preventative Health Database Report showed that out of 413 possible points of compliance for immunizations, 405 points had been achieved for a compliance rate of 98.6%. The report showed that out of 187 possible points of compliance for preventative health care screenings, 183 points were achieved for a compliance rate of 97.86%. The database contained updates to all initially surveyed baseline records that were deficient. New admissions were also included. The database also contained analysis and trending information that included: Actions taken to move toward compliance; Improvements made since the last monitoring Team's review; and future plans of improvement. Data derived from the analysis and trending of immunization and preventative healthcare screenings were represented in tabular and scatter plot graphs. Up dating the Comprehensive Preventative Health Database was an on going process. Plans of correction were implemented when deficiencies were identified in immunizations and/or preventative healthcare screenings. • Since the last review, Joint Commission cited the Facility for having poor hand hygiene compliance as well as inconsistent and conflicting hand hygiene policy knowledge by nurses and other staff. The Health Care Guidelines also requires compliance with hand hygiene. The ICP Nurse and some supervisors instituted testing on the staff's knowledge of the Standard Operating Procedure, EC 403-05, and confirmed the lack of knowledge and cooperation. As a result of these findings a Plan of Correction was implemented on 8/12/2011 to remedy the poor hand hygiene compliance. It was positive to find that the ICP Nurse had established a thorough Plan of Correction for hand hygiene practices. At the next compliance the Monitoring Team will review effectiveness of the plan through observation and by reviewing the data the Facility gathers in evaluate effectiveness of the Plan.	

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		A review of the infectious and communicable disease reports, including healthcare acquired infections, indicated they were tracked, analyzed and trended monthly and quarterly as were the handwashing and environmental surveillance data. These data are reviewed, discussed, and plans of correction developed, as needed, at Safety/Risk Management/Infection Control Committee Meetings and results documented in the minutes. A review of the Safety/Risk Management/Infection Control Committee Meeting Minutes found that infectious and communicable diseases, including healthcare acquired and nosocomial rates were consistently reported in the minutes. However, there were no reports of possible infectious and or communicable disease trends identified from the data. This was of concern due to a review of the Monthly Infection Reports, March through June, 2011, consistently reported cases of tinea pedis (Athlete's foot) and conjunctivitis, both of which were spread through cross-contamination. There was no documented evidence in the minutes or elsewhere that these cases were identified as trends. When there are monthly occurrences of contagious diseases reported, the ICP Nurse should evaluate the data for possible trends, conduct an infection control investigation to identify contributing factors that may have caused the spread of the disease processes, and take corrective action to prevent the spread of communicable disease. The ICP Nurse continued to track and report infectious and communicable diseases according to CDC/public health requirements. It was positive to find that there were no reportable cases for the following communicable diseases: Methicillin-resistant Staphylococcus aureus; Active Hepatitis A, B, and C; newly converted Tuberculin Skin Tests, Clostridium Difficile, H1N1 (swine flu), and Sexually Transmitted Disease. There were two cases of Hepatitis B Carriers, and nine cases of past positive Tuberculin Skin Tests. The ICP Nurse needs to ensure that follow-up protocols are in place and implemented for cases of Hepatitis B carriers and positive Tuberculin Skin Tests. A review of the Hand Hygiene and Environmental Surveillance Reports found evidence that when deficiencies were identified plans of correction were implemented and followed through to resolution. This was a positive finding. Although the infectious and communicable disease, healthcare acquired infections and handwashing and environmental surveillance monitoring were completed, tracked, analyzed and trending monthly and quarterly, the Facility did not have formalized monitoring process in place to describe the staff responsible for monitoring, size of the sample, the frequency of the monitoring, and how plans of corrections were developed, implemented, and tracked though to resolution. The ICP Nurse reported that he planned	

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		to increase environmental surveillance monitoring from once a quarter to monthly in each program area and to issue corrective Action Plans for any deficiencies found. There was no formalized system in place to ensure the reliability of the data reported on infectious and communicable diseases. The ICP Nurse stated that he was responsible for reporting all cases, and was receiving copies from the lab of all notified lab results, at the same time the units received results. The ICP Nurse should put a system in place to ensure the reliability of the infectious and communicable disease reports. Crosschecking the Pharmacy's antibiotic usage log would be one of any number of ways to identify cases of infectious and communicable diseases. The Settlement Agreement and Health Care Guidelines requires that the Infection Control Program and/or Pharmacy Department monitors the use of antibiotic prescribing practices within the Facility, and responds with additional training and other interventions as needed. There was no documentation supplied to indicate that there was a monitoring system in place addressing the requirement that staff practice Standard Precautions at all times, as required by the Settlement Agreement and Health Care Guidelines. Since the last review, the State-wide Infection Control Nurses' Workgroup had finalized the Infection Control Reference Manual. The Infection Control Nurse Workgroup did not develop a training component for the Manual nor had the Facility. Consequently, no training on the Manual had been provided to the nursing staff or other relevant staff. It is important that the nursing staff and other relevant staff receive training on changes in current infection control practices, regulations/standards, e.g., Centers for Communicable Diseases (CDC), Occupational Safety and Health Administration (OSHA), and other changes inherent for managing an infection control program that affects long term care facilities. The ICP Nurse stated that the Facility had updated their Infection Control Policy. The Facility used the required Infection Control Training Curriculum, revised 2003, developed by the State's Human Resource Development, Texas Department of Mental Health and Mental Retardation, which was seriously outdated. Many changes in Infection Control practices and regulations/standards have changed since it was developed. This training curriculum needs to be updated. A copy of Competency Training and Development's Due and Delinquent Training Report was not available for review as requested. The ICP Nurse reported, per CTD, that infection control training for present staff was at 95% or greater. Although there had been measurable improvements made in most aspects of the Infection Control Program, the Monitoring Team did not find that the Facility had yet met	

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		substantial compliance with this requirement of the provision. However, the Facility was found to be close to compliance based on the positive practices identified in the report. In order to achieve compliance regarding infection control the positive practices identified in the report must be maintained and improvements made in other areas of practice. The Infection Control Program should make the following improvements: • Ensure that the Hand Hygiene Plan of Correction is followed through to resolution and good hand hygiene practices are maintained. • Develop and implement a system for checking the reliability of infectious and communicable disease reports to ensure that all cases are reported timely and completely. • Collaborate with the Pharmacy Department to monitor the use of antibiotic prescribing practices within the Facility, and respond with additional training and other interventions as needed. • Ensure that a monitoring system is in place to ensure that staff practice Standard Precautions at all times. <u>Medical Emergency Response</u> It was positive to find that since the last review, the Facility had placed several pieces of emergency equipment, including an AED, Ambu Bag, and Red Emergency Bag, in the Vocational Services area. The only equipment lacking was an oxygen tank and suction machine. The Chief Nurse Executive (CNE) stated the reason the oxygen was not placed in the Vocational Service area was due to concerns over safety. Upon further discussion the CNE decided to order a small lightweight "Walkabout" oxygen system with a shoulder strap that could be easily transported to the Vocational Service area by the nursing staff. The reason a suction machine was not in place was due to lack of an electrical extension cord that meets safety standards, when one is obtained a suction machine will be placed in the Vocational Services area. Two rolling carts had been ordered for the Facility, but not yet received, to transport emergency equipment where it might be needed in the living units. Since the last review, it was positive to find that the Facility had developed and distributed an AED list describing their locations and other pertinent information. Signs were posted throughout the Facility identifying the location of the AEDs, as was evidenced through the Monitoring Team's tours of the Facility. Since the last review, the Monitoring Team reviewed the past five months' Emergency Equipment Checklists, including AEDs; and confirmed that the nursing staff checked and signed the emergency equipment daily. As was recommended at the last review, the Nurse Managers or designees checked and signed the Emergency Equipment Checklist monthly to ensure that all emergency equipment was checked daily.	

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		The Facility had a public address system to announce the Mock Medical Emergency Drills as well as Code Blue events. The CNE stated that mobile radios had been ordered, but not yet received, for the nurses to use when they were away from the desk phone and needed to be contacted. A review of the past six months completed Mock Medical Emergency Drill Forms, showed significant improvement from previous drills. There was evidence that the nursing staff consistently participated in the drills; and emergency equipment was checked for working order. When drills were failed there was documentation in the comment sections of the drill forms describing the reason for failure and the Plan of Action section described the action taken to remedy the failed response. Corrective actions were typically taken "on the spot" but if the drills were repeated and specific staff did not perform correctly there was evidence that they were sent for formal retraining. As was noted in previous reviews, the physicians failed to participate in the drills. Unless there was justifiable cause the physicians should participate in the drills. Since the last review, the staff responsible for coordinating and conducting the Mock Medical Emergency Drills had changed. The Interim Vocational Services Manager who was given the responsibly for this function was interviewed. When asked for a schedule to indicate whether drills were completed as required, he said he did not have a schedule or an internal operating procedure for conducting the drills. He stated that he just knew when to conduct them. This was discussed with the ICF-MR Director who stated that it was recommended at the last review to develop and implement a Mock Medical Emergency Drill Schedule. She stated that the schedule had been developed and provided to the previous drill coordinator, but the schedule had not been passed on the current coordinator. This problem was resolved "on the spot" by the ICF-MR Director and a copy of the schedule was provided to the current drill coordinator. While the schedule listed the date and locations of the drills, it did not indicate that they were completed according to the schedule. The ICF-MR Director immediately met with the Interim Vocational Services Manager and the Safety and Risk Management Director and developed an action plan. The plan included providing both the Interim Vocational Services Manager and the Safety and Risk Management Director with a copy of the drill schedule so that if either one of them should resign or not be available, the other is able to ensure that the drills occur on schedule. The Interim Vocational Services Manager will maintain the drill log and schedule and report the outcome of the drills at the Safety and Risk Management Committee Meetings. Reporting on the analysis and trending of Mock Medical Emergency Drills and other performance issues was a standing agenda item, and therefore; should the Interim Vocational Manager be unavailable, the Risk Management	

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		Director will be able to provide the information and updates at the committee meetings. Further concerns regarding the Mock Medical Emergency Drills (Emergency Response) reports in the Safety/Risk Management/Infection Control Committee Meeting, was discussed with the ICF-MR Director, Interim Vocational Services Manager, and CNE. The concerns included: Many topics were discussed at the committee meetings, thus the amount of time was limited for all topics. The allotted time to review and discuss the outcome of Mock Medical Emergency Drills was limited to five minutes. The CNE was not a standing member of the committee. As part of the plan of correction mentioned above, if the allocated amount of time is not adequate to report on the drills, an additional meeting will be called. The CNE should also become a member of the committee and become more involved with the drill and/or emergency response process. An impromptu Mock Medical Emergency Drill was not conducted at this review. This was due in part to observing the nursing staffs' prompt emergency response during the Risk Assessment Meeting for Individual #40; who experience seizure activity. A review of the Competency Training and Development (CTD) Report, dated 7/28/2011, indicated that the nursing staff was current in Emergency Response Training. A CTD report for Emergency Response Training was not available to review for other required staff/disciplines. Although there had been some improvements made, this requirement of the provision was not found in compliance; but was close to meeting compliance with the positive practices identified through the review. In order to meet compliance with this requirement, the Facility must maintain the positive practices identified in the report and make improvements on the following practices: • Maintain a Mock Medical Emergency Drill Schedule that also validates that drills were completed as scheduled. • Ensure that adequate time is allocated at the Safety/Risk Management/Infection Control Committee Meeting, to thoroughly review and discuss the results of the Mock Medical Emergency Drills and/or emergency response, develop plans of correction, and follow through to resolution. • The physicians should participate in the drill unless there is a justifiable reason they could not participate. • The CNE or nursing designee should become a standing member on the Safety/Risk Management/Infection Control Committee. The Facility should ensure that all required staff/disciplines are current in Emergency Response Training. <u>Quality Enhancement Efforts</u>	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>According to the Facility's Section M of the POI, since the last review, only one record was audited per quarter using the 12 Nursing Care Monitoring Tools. The Nursing Operation Officer (NOO) and the QA Nurse conducted the audits. The CNE and QA Nurse both agreed that this procedure was not adequate to supply meaningful data. According to the POI, starting 9/1/2011 the number of records audited using the Nursing Care: Monitoring Tools will increase from one record per quarter to four records per month utilizing Nursing Care Monitoring Tools for: Annual and Quarterly Nursing Assessment, Annual Nursing Care Plans, Acute Injury/Illness Monitoring Tools, Urgent Care/Emergency Room Visits and Hospitalization, and Medication Administration. The Nurse Case Managers will be responsible for conducting these audits, with the QA Nurse validating the data. The NOO will review the results of the monitoring data quarterly at the Settlement Agreement - Plan of Improvement Committee (SA-PIC) meetings; and corrective action plans (CAPs) will be developed and implemented based on the data reviewed. Monitoring tools must meet 80% or above to be considered compliant, any percentage falling below 80% will have a CAP developed and followed monthly. The method used for selecting record samples was not included in Section M's POI. The POI did not describe how the QA Nurse would validate the data monitored. The POI did not indicate if the additional Nursing Care: Monitoring Tools would be used.

A review of the Quality Enhancement: Section M, I and Q Monitoring Tools Reports for the Third and Forth Quarters FY2011 revealed the following information:
<table>
<tr><th>Section M and Q Monitoring</th><th>3rd Quarter FY 2011</th><th>4th Quarter FY 2011</th></tr>
<tr><td>1. Medication Administration and Documentation</td><td>97%</td><td>98%</td></tr>
<tr><td>2. Urgent Care/Emergency Room Visits, and Hospitalizations</td><td>69%</td><td>N/A (individual did not have any urgent care/emergency room or hospitalizations)</td></tr>
<tr><td>3. Acute Illness and Injury</td><td>47%</td><td>100%</td></tr>
<tr><td>4. Documentation</td><td>64%</td><td>60%</td></tr>
<tr><td>5. Infection Control</td><td>100%</td><td>73%</td></tr>
<tr><td>6. Management of Chronic Respiratory Distress</td><td>100%</td><td>N/A (individual did not have chronic respiratory distress)</td></tr>
<tr><td>7. Annual Nursing Care Plans</td><td>20%</td><td></td></tr>
<tr><td>8. Pain Management</td><td>88%</td><td>0%</td></tr>
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9. Prevention	45%	67%
10. Seizure Management	N/A (individual did not have a seizure diagnosis)	N/A (individual did not have a seizure diagnosis)
11. Skin Integrity Assessment	60%	100%
12. Annual/Quarterly Nursing Assessment	65%	77%
13. Dental	72%	77%
14. Section I – At Risk Individuals	45%	0%

The Monitoring Team agrees with the CNE and QA Nurse that this sample was too small to provide meaningful data from which to develop CAPs. However, this data did begin to indicate areas of deficiencies. A CAP was not developed and/or available for review for tools falling below 80% compliance. As the number of records monitored increase and the system becomes more refined; the content and the quality of the data should improve to provide the Nursing Department more reliable data from which CAPs can be developed and implemented to correct areas of deficiencies in nursing practices.

The POI stated the At Risk Policy was implemented 5/1/2011, and that the NOO would be monitoring Section I. However, the Action Step indicated that the Qualified Mental Retardation Professional (QMRP) and ICF Consultant or designee would monitor Section I.1, I.2, and I.3. This information was contradictory and should be clarified as to which staff has the responsibility for monitoring this section. There was no Quality Enhancement data on Section I included in the documents reviewed.

In addition to the Nursing Care: Monitoring Tools mentioned above, the Nursing Department conducted monthly audits on six records for 24 Hour Chart Checks. Items monitored included:

- Checking Physician Order's to make sure all orders were carried out.
- Checking Physician Orders for medical and dental appointments to ensure that appointments were entered in the database to prevent missed appointments and/or to reschedule appointments when indicated.

The data summary, March through July, 2011, for 24 Hour Chart Checks and Scheduled Appointments found an overall compliance of 88% and 86% respectively. The Facility reported the audits and their outcomes had helped the entire Facility, not only the department for which the incident of missed orders had been prevented, but also in ensuring that appointments were made in a timely manner, not missed and/or were rescheduled when indicated. This assured that individuals received their necessary care.

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		Corrective actions were taken on monthly audits with a compliance rate falling below 100%. The audit data were entered on the Results of Monthly Audits for ICF-MR Tags Reports. The QA Nurse also conducted monthly audits on six Medication Administration Records. Refer to Provision M.6 for the results of these audits. This requirement of the provision was not found in compliance. In order for the Facility to meet compliance with this provision positive practices identified in the report must be maintained and improvements made in other practices. The Quality Enhancement and Nursing Departments should make the following improvements: • All Nursing Care: Monitoring Tools should be used at some point. The Nursing Department should develop a plan for more thorough use of tools in conjunction with the QA program at the Facility and with DADS. • The Nursing Department and/or Quality Enhancement Department should ensure Nurse Case Managers completing the monitoring tools are adequately trained on their use, including the tools' guidelines. Emphasis must be placed on evaluating the quality of the nursing care rendered. • Quality Enhancement procedures and processes for auditing the Nursing Care: Monitoring Tools should be formalized and refined, particularly for: method used for selecting samples, reliability checks conducted by the QA Nurse, and Corrective Action Plans.	
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.	In response to consistent past findings indicating significant problems regarding nursing's competency related to overall nursing assessment, the State developed and implemented a Physical Assessment Class on 3/2011, which also included additional instruction on documentation. This class was designed for all RN levels of nursing staff. The training program consisted of a day of classroom instruction, followed by a day of competency-based demonstrations of assessment skills, which the RN participants performed on each other. Additional competency-based demonstrations of assessment skills were to be conducted for quarterly assessments, a chronic condition follow-up, and an acute illness review and/or clinic follow-up. These demonstrated competencies would be completed with an individual assigned to the RN Case Manager's caseload, and would be supervised by the Nurse Practitioner trainers. Based on past review of the Physical Assessment Competency Guidelines for Evaluation (draft), the curriculum and training being provided was thorough and reflective of appropriate competency-based training for nursing assessment skills. From an earlier discussion with the State Office Nursing Coordinator, once all RNs at State Supportive Living Centers had completed the training, LVNs also would be provided competency-based training on assessments in alignment with their licensure.	Noncompliance

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		The Infection Control Preventionist/Nurse Educator was the only Facility nurse who had completed the Physical Assessment Class. Unfortunately, the Infection Control Preventionist/Nurse Educator no longer functions as the Nurse Educator because of assuming full time responsibility for the Infection Control Program. The CNE stated the Nurse Educator position was posted and was being actively recruited. As soon as the Nurse Educator position is filled, the nurse will be sent to the Physical Assessment Class and will train the RN staff. Although some steady improvement was noted in completing Annual and Quarterly Nursing Assessments the nursing staff needs additional training to improve competency in performing physical assessments. A sample of twenty-three Annual and Quarterly Comprehensive Nursing Assessments were reviewed for Individuals: #27, #126, #108, #5, #47, #54, and #11; three Admission Comprehensive Nursing Assessments were reviewed for Individuals #40, #115, and #134. A total of 26 assessments were reviewed. The review revealed the following findings: • Three of three (100%) new Admission Comprehensive Nursing Assessments were completed with in 30 days. • Two of 23 (9%) Annual and/or Quarterly Comprehensive Nursing Assessments were completed according to their respective PSP Schedule. • 26 of 26 (100%) Comprehensive Nursing Assessments were completed by a RN. • 26 of 26 (100%) Comprehensive Nursing Assessment had BRADEN skin integrity assessments completed. Most of the Comprehensive Nursing Assessments, Sections I through X, showed some improvement in the physical assessment of systems and the accompanying summary describing findings of the physical examination. Trends of deficiencies identified in these section included: • When new nursing problems/diagnoses were identified or when risk levels changed, revisions were not made until the following annual/quarterly assessments were completed. • The nursing problems/diagnoses did not always contain a HMP. Frequently HMPs were found for which there was no nursing problem/diagnosis listed. • Immunization status for measles, mumps, and rubella (MMRs) and Hepatitis were not documented. Overdue immunizations, such as tetanus/diphtheria, were not addressed. • There was failure to recognize and address significant increased or decreased changes in weight and BMI from year to year and/or quarter to quarter. • Meal monitoring was not consistently completed. • Occasionally baseline vital signs and oxygen saturation levels were not completed. • The effectiveness of medications was not consistently documented.	

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		• Female monthly and annual male breast exam were not always completed. • Female –Gynecological status (Menopausal, menstrual patterns, Pap smears) were not consistently assessed. Examples of the above included: • Individual #108 did not have meal monitoring or current weight completed on the 8/12/11 Quarterly Comprehensive Nursing Assessment. On 5/27/11, Quarterly Comprehensive Nursing Assessment the monthly breast exam and Gynecological status were not completed. • Individual #5 had active problems for Prader-Willi, Type II Diabetes, and Obesity with a BMI of 35. His Annual and Quarterly Comprehensive Nursing Assessments for 2/16/11, 5/16/11, and 8/14/11 indicated his was 57 pounds or 64% above the upper limit of his desired weight limit. He was receiving a regular 1500 calorie, ADA, low fat diet. The Weight Management Summary sections did not include a summary describing compliance with the diet or other weight management issues, although he had a HMP for imbalanced nutrition related to overweight. Neither did the Section XI nursing summaries describe his progress toward weight management goals and objectives or the effectiveness of the plan of care. There was no documentation of collaboration with the PNMT regarding weight management issues. • Individual #40 was identified in the 8/13/11 Quarterly Comprehensive Nursing Assessment has having lost 22 pounds since admission on 4/18/11 (within three months) resulting in a 17% weight loss in three months. The Weight Management section summary and Section XI nursing summary stated the weight loss of 22 pounds was attributed to meal refusal, being a very picky eater, increased maladaptive behaviors, and increased physical activity. The nurse stated the concern regarding weight loss should be addressed. However, there was no documentation of collaboration with the physician, PNMT, or behavior analyst/psychologist. Neither was there an Acute Care Plan (ACP) developed to monitor weight loss. The weight loss of 17% in three months was significant, regardless of the reasons the staff thought might have contributed to the weight loss; this problem should have been identified and addressed earlier. None (0%) of the Section XI nursing summaries were adequate to effectively demonstrate individuals' heath status related to their identified nursing problems/diagnoses in terms of progress made toward the problems' established goals and objectives. As had been identified in all previous reviews, the summaries continued to contain raw clinical data related to: Past and present listings of surgeries, illnesses and injuries, treatment modalities, testing and diagnostic results, consults, hospitalizations, emergency room, and sick call visits. Occasionally the effectiveness of the treatment modalities was mentioned and the outcome of the testing and/or	

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		diagnostic results reported. However, the overall impact of these issues on individuals' heath status for their identified problems was not summarized. The summaries described interventions and activities related to the plans of care for the identified problems but failed to summarize the effectiveness of the plans and individuals' response to the plans. The effectiveness of HMPs or any changes needed or made to the HMPs were not summarized in a meaningful or useful way for the PST to use in measuring individuals health status progress annually and/or quarterly. The purposes of completing the Comprehensive Nursing Assessment are to identify health problems, establish goals and objectives to be attained through effective plans of care, and complete meaningful and useful summaries stating individuals' health status for each identified problem at the time of their annual and quarterly PST meetings. There was no consistent format used for writing the summaries and the format varied among Nurse Case Managers. The Nursing Department should pick one consistent format to use for writing the Comprehensive Nursing Assessment, Section XI for nursing summaries to ensure continuity for the nurses to write and for the readers to understand. It was apparent the RN Case Managers were struggling with this issue. The Nurse Case Managers who completed the above assessments need the Physical Assessment Class. The competency-based training is essential to the forward movement towards compliance with the Settlement Agreement previsions related to nursing clinical practices. In order for the Facility to meet compliance with this provision they need to maintain positive practices identified in the report and improvements made in other practices. The Nursing Department should make the following improvements: • Ensure that the Nurse Case Managers receive the Physical Assessment Class as soon as possible. • Ensure that the Nurse Case Managers receive training on how to summarize raw clinical data in Comprehensive Nursing Assessments, Section XI for Nursing Summaries. • Develop a standardized format for writing nursing summaries in the Comprehensive Nursing Assessments, Section XI. • Ensure Nurse Case Managers include all high and medium risk levels and any other chronic conditions requiring monitoring in the Comprehensive Nursing Assessments, Section X for nursing problems/diagnoses and that care plans are developed and implements for each problem/diagnosis identified. • Ensure that Annual and Quarterly Comprehensive Nursing Assessment are completed according to the PSP schedule.	

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M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	Since the last review, it was positive to find documentation that the nursing staff had consistently trained the direct care professionals on their respective responsibilities on individuals HMPs and ACPs. A review of 87 of 87 (100%) HMPs and ACPs for Individuals #82, #5, #108, #31, #63, #85, #96, #4, #66, #23, #47, #79, #54, #98, #97, #107, #19, #76, #61, #27, #118, #139, #40, #140, #1, #69, #134, and #80, showed that the nursing staff had developed, implemented, and trained direct care professionals on the special instruction sheets for each of the care plans. Unfortunately, during the review the Monitoring Team discovered that the special instruction sheet had been removed from the Me Books. The NOO stated Health Information Management staff hand removed the special instruction sheet from the Me Books. The special instruction sheets had been put in binders in the nurses' offices. This rendered them inaccessible and useless to the direct care professionals since they do not have access to the nurses' offices. It was of concern that upon the discovery of their removal that the Nursing Department had not immediately pursued the reason for removal and taken corrective action to remedy the problem to ensure that this vital information was returned to the Me Books. The ICF-MR Director was notified of the removal of the special instructions from the Me Books. The Director immediately came to the nurses' office to investigate the problem. She stated she was not aware that the special instruction sheets for the care plans had been removed from the Me Books. Upon review of the situation she stated they were removed because the nurses had not gotten an approval by the Records Committee for a record number so they could be officially added to the Me Book Index and put in the books. As a result of the meeting, the ICF-MR Director sent an e-mail to the Record Committee requesting a meeting the next day to resolve the problem. The Facility needs to promptly resolve the problem to ensure that record numbers are obtained and that the special instruction sheets for care plans are returned to the Me Books. The Monitoring Team will follow-up on this issue at the next review. A review of the HMPs and ACPs found that the older versions of the healthcare plans were no longer used. A sample of nineteen HMPs and ACPs were reviewed for Individuals #27, #126, #108, #5, #47, #54, #40, #115, and 134. Trends identified reveal the following: • Eight of 15 (53%) of the HMPs were reviewed/revised at the time of the Annual and/or Quarterly Comprehensive Assessments. • One of 15 (7%) HMP was individualized. • Two of four (50%) of the ACPs contained documentation that the acute problem was resolved. 14 of 15 (93%) of HMPs were not individualized. • Zero of 19 (0%) 19 HMPs and ACPs indicated they were integrated with other	Noncompliance

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		disciplines. • Of the HMPs and ACPs that were reviewed, the same issues were identified as in past reviews. They included the following issues: o Except for the baseline data, the goals and remainder of the HMPs and ACPs lacked individualization and were printed and signed from the care plan stock. o The HMPs lacked criteria for documentation, including the frequency for which interventions were to be performed, by whom, where documentation was to be located, how often and by whom were the plans to be reviewed. o Lack of preventative and/or proactive interventions. o Lack of documentation in the Integrated Progress Notes and/or Annual and Quarterly summaries that interventions were implemented and their effectiveness. o Not all identified high or medium risk levels or chronic conditions that were unstable or required routine monitoring had HMPs. o Frequently there was a delay of several days from the time there was an identified change in status until a HMP and/or ACP was initiated. According to nursing's Care Plan Development Policy, an ACP should be developed and implemented with 12 hours of the identified change in status. A HMP should be developed and implemented as soon as possible after an identified change in status that requires a long-term care plan. o Most frequently missing were HMPs and/or ACPs for psychoactive medication, particularly when new psychoactive medications were prescribed, or when current psychoactive medications were increased, decreased or tapered off. o HMPs for psychoactive medications were generic, the specific psychoactive medications and their potential side effects and adverse drug reactions were not listed. For example, Individual #11 had a generic Psychotropic Medication HMP. However, Lithium was added to the existing psychoactive medication with several dose adjustments up and down. Lithium has unique side effects some of which differ from other psychoactive medication and requires care monitoring. The HMP should have been revised to include Lithium when it was added as well as the other specific psychoactive medication he was receiving and/or an ACP should have been initiated when the Lithium dosing was being adjusted. In order to meet compliance with this provision, positive practices identified in the report must be maintained, and the other improvements should be made. The Nursing Department should make the following improvements to HMPs and ACPs: • Individualize HMPs and ACPs to address individuals' unique problems and circumstances. Include accurate baseline data regarding the problems and realistic,	

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		observable, and measurable goals and objectives. • HMPs and ACPs should be integrated--developed and implemented in collaboration with other relevant disciplines. • The HMP should include criteria for documentation, including the frequency interventions are to be performed, by whom, where documentation is located, how often, and by whom the plans are reviewed. • Promptly initiate a HMP and/or ACP when there is a significant change in an individual's health status. • HMPs for psychoactive medication should include the name of each medication and their specific side effects and adverse reactions.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	The Nursing Department continued to maintain an excellent Nursing Training and Tracking Database, which included the names of the topics taught, number of nurses trained on each topic, percentage of total nurses that received training on each topic, and the projected completion date for each topic. In addition, signed Training Rosters for each topic were maintained in binders. The Monitoring Team reviewed the training database and training rosters and verified previous training completed and the projected dates established to complete 100% for the required training on each topic. Since the last review all of the State Supported Living Center CNE Workgroup nursing policies, procedures, processes, and protocols were finalized and issued to the Facility. The Nurse Educator Workgroup's Nursing Education Handbook Manual was finalized, and issued to the Facility for implementation in 9/2011. According to the CNE the staff had not been trained on all of the State nursing policies, procedures, processes, and protocols. Neither had training begun using the Nursing Education Handbook Manual. She stated with the loss of the part-time Nurse Educator it had been difficult for the Nurse Managers and Nurse Case Managers to complete all of the training needed due to their other responsibilities. She said the Nurse Educator position had been posted and was being actively recruited. The part-time Nurse Educator had completed the mandatory Physical Assessment Class in May, 2011. When the Nurse Educator position is filled, the nurse will be scheduled for the Physical Assessment Class, and then will assume the responsibility for teaching the class to the RN staff. The Facility continued to use the Health Care Protocols for Developmental Disability Nurses for developing Health Maintenance and Acute Care Plans. Refer to Provision M.2 for more information. It was positive to find the Nursing Department planned to continue teaching the Common Signs and Symptoms of Acute Illnesses and Injuries Curriculum at the New Employee Orientation and at annual refresher training once the Nurse Educator position	Noncompliance

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		is filled. This is an important class which teaches how to recognize, respond and report signs and symptoms of acute illnesses and/or injuries, particularly for the direct care professionals who are usually the first staff to recognize changes in individuals' health status. In order for the Facility to meet compliance with this provision, positive practices identified in the report must be maintained and improvements made in other practices. The Nursing Department should make the following improvements regarding training: • Fill the full-time Nurse Educator position as soon as possible. • Ensure that the Nurse Educator receives the mandatory Physical Assessment Class as soon as possible. • Ensure that 100% of the nursing staff are trained on all State nursing policies, procedures, and protocols, as well as in any other required policies, procedures, and protocols refresher training. • Implement training from the competency-based Nursing Education Handbook Manual for New Nurse Orientation and refresher training. • Ensure that all nursing training is competency-based.	
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 review, the nursing staff continued completing At Risk Screening Assessments in conjunction with the individual's primary care physician. They were responsible for assessing risk factors for the following categories: Aspiration, Respiratory Compromise, Cardiac Disease, Constipation/Bowel Obstruction, Diabetes, Gastrointestinal Problems, Osteoporosis, Seizures, Skin Integrity, Infections, Fractures, Fluid Imbalance, Hypothermia, Urinary Tract Infections, and, Circulatory. The Nurse Case Managers attended and participated in the PSP/At Risk meetings. To assess the Facility's At Risk Screening process, members of the Monitoring Team observed two individuals' PSP/At Risk meetings (Individual #40 and Individual #80). The Monitoring Team observed improvements in the PSP/At Risk Screening process since past compliance reviews. The level of interdisciplinary participation and discussion, including direct care professionals, was significantly improved. The Monitoring Team encouraged the PSTs to go beyond the scripted guidelines when reviewing and discussing levels of risk. During the PSP/At Risk meeting for Individual #40, several PST members stated that he would be calm and then have an outburst of maladaptive/aggressive behavior, then would appear sleepy, would fall asleep, and was observed by one member to become incontinent of urine during/after the episode. None of the team members had associated these maladaptive behavioral episodes with seizure activity, although he had a history of seizures and was receiving anticonvulsant medications. During this discussion,	Noncompliance

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		Individual #40 was sitting in a chair when his eyes began rolling upward and was unresponsive when his name was called. The team decided to rule out seizure activity versus behavioral issues. At the risk screening meeting the team decided to rate seizures as a medium risk until further evaluated. The physician sent Individual #40 to the emergency room for evaluation; he was subsequently admitted with a diagnosis of generalized/focal seizures. Individual #40 continued in the hospital for evaluation at the time the review was over on 8/26/11. Therefore, the outcome of Individual #40's evaluation was not determined. The Facility should ensure that the PST receives training on recognizing different types of seizure activity. A review of At Risk Screening Assessments, PSPs, and PSPA for Individuals #40, #27, #126, #108, #5, #47, and #54, identified the following problematic trends: • Zero of seven (0%) assessments met all of the requirements for Section I of the Settlement Agreements. • One of seven (14%) PSP's and PSPAs' included adequate Action Plans to address all identified risk levels. • The completed At Risk Screening forms were not placed in individuals' records. Apparently, this was due to lack of a record number for the At Risk Screening form. Occasionally individuals' risk levels were included in their PSPs. • When the completed At Risk Screening records were found, they failed to clearly and/or consistently identify the rationale for the decision made for the respective risk factor. Service plan objectives for the responsible disciplines were not identified on the risk screening forms. • The Facility did not consistently integrate individuals' identified risks into their PSPs/PSPAs. • PSPs/PSPAs Action Plans for individuals' identified risks did not consistently contain measurable steps taken to reach the desired outcome, implementation dates, responsible person, where the activity occurs, how often or due date, where to record, and completion date. PSPs/PSPAs did not consistently match individuals' identified risk levels. • The Facility did not use the At Risk Action Plan form. • At Risk Screenings were not consistently completed after individuals were hospitalized or identified to have change in status. Examples of failure to complete risk assessments following hospitalization included: • Individual #54 was admitted to the hospital on 4/13/11 and discharged on 4/21/11 for severe constipation and was diagnosed with a partial small bowel obstruction that was relieved without surgical intervention. Prior to the hospitalization Individual #54 was assessed at medium risk for constipation and bowel obstruction. There was no At Risk Screening conducted after the hospitalization. Because of the	

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		potential to redevelop bowel obstructions, the PST should have re-assessed the risk level for constipation and bowel obstruction and changed it, at least temporarily, to a high risk level. While in the hospital Individual #54 was diagnosed with aspiration pneumonia. There was no At Risk Screening conducted after the hospitalization. The level of risk for aspiration pneumonia should have been re-assessed. Individual #54 had a Modified Barium Swallow Study on 5/5/11, which indicated silent aspiration and the need to transition to nectar consistency liquids. There was at least a 13 day delay before liquids were changed to nectar consistency which could have put her at risk for another episode of aspiration pneumonia. Again there was no At Risk Screening conducted after the Modified Barium Swallow. • Individual #27 was admitted to the hospital 6/24/11 through 6/27/11 for a cholecystomy. There was no At Risk Screening conducted after hospitalization. This was a significant change in status and should have been re-assessed for post-operative status and a plan of care. • Individual #5 was admitted to the hospital on 6/8/11 and diagnosed with Deep Vein Thrombosis (DVT) of the left leg and place on anticoagulant therapy. There was no At Risk Screening conducted after hospitalization. The development of the DVT resulted in a significant change in status and should have indicated a high risk level for circulatory status. The Nurse Case Managers need to collaborate with physicians and other appropriate disciplines when completing At Risk Screenings to ensure that all relevant medical/health data are collected and accurate for presentation at the PST/At Risk meetings. Refer to Section I for additional information.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally	Since the last review a schedule for Medication Administration Observation had been developed and implemented. A review of the Medication Administration Observation Schedule found that the nursing staff were scheduled for quarterly review. It was the Nurse Managers' responsibility to ensure that quarterly observations were completed; the data analyzed and trended; and plans of correction developed, implemented and followed through to resolution. However, there was no documentation supplied for review that validated that the scheduled observations had occurred or that observation data were analyzed, trended, and plans of correction developed, implemented, and followed through to resolution. The POI Action Step indicated that the Nurse Manager would begin auditing the Medication Administration Observations according to the Medication Administration Monitoring Tool on 9/1/2011. Completing Medication Administration Observations is a basic standard of nursing practice to ensure that nursing staff administering medication perform competently. The recommendation to complete quarterly Medication Administration Observations had been addressed on all previous reviews. This requirement was identified as a standard of practice to be	Noncompliance

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	accepted professional standards of care with regard to this provision in a separate monitoring plan.	assessed for compliance with this provision of the Settlement Agreement. The Monitoring Team accompanied by the Nursing Administrative/Management, and QA Nurse, conducted Medication Administration Observations in El Paisano and La Paloma during the afternoon medication passes on 8/25/11. Several problematic issues were identified during the observations. In La Paloma the nurse was observed passing medications through the Dutch door. Several individuals were crowded around the front of the door preventing privacy for the individual receiving medication and had the potential to interfere with the nurse's concentration to safely administer medications. There were no direct care professionals assisting the nurse by bringing one individual at a time to the door to receive medication. The Nurse Manager went to the Home Manager/Supervisor who was at the dorm station in the hallway and requested assistance for the nurse. The Nurse Manager reported that the Home Manager/Supervisor said she had no staff to assist the nurse. When the Nurse Manager told her that this would be reported, the Home Manager/Supervisor expressed a lack of concern regarding being reported. Although the Home Manager/Supervisor may not have had staff to assist the nurse, a prudent Home Manager/Supervisor would have assisted the nurse. This demonstrated very poor performance of supervisory skills, the inability to work effectively in an integrated setting, and a lack of regard for the safety and welfare of the individuals. The failure to the Home Manager/Supervisor to assist the nurse administering medication was reported to the ICF-MR Director who stated she would interview the Nurse Manager regarding the incident and take corrective action as indicated. Similarly, as the Monitoring Team approached the Dutch door in El Paisano, for medication administration observation at the 4:00 p.m. medication pass on 8/25/2011, there was no direct care professional assisting the nurse. Several individuals were standing at the door waiting for medication. The Nurse Manager requested assistance for the nurse, which was provided without difficulty. Then one individual at a time was brought to the door to receive medication. This created a calm physical environment in front of the door conducive to administer medication without undue interruptions. However, several problematic issues were observed with the nurse's competency administering medications: • The nurse failed to check the Medication Administration Records (MARs) to review individuals' pictures for correct identification and the Physical and Nutritional Management Plan (PNMP) for special instruction for administering medication. When asked why these items were not checked, she stated she had been working with these individuals for some time and knew who they were and knew of any special PNMP instructions for medication administration. The nurse also showed the Monitoring Team a list of individuals' special instructions for medication	

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		administration posted on the refrigerator located beside the medication cart that could be referred to if needed. • The nurse failed to perform the three basic checks before administering medications, that is., when removing the medication from the storage container check it with the MAR, check the medication with the MAR when pouring medication into a container for administration, and check again with the MAR after placing medication in the container for administration. The nurse only completed one check with the MAR when the medications were removed from the medication cart. • The nurse prepared Individual #51's medication and was prepared to give the medication whole. The Monitoring Team prompted the nurse that his PNMP required the medication to be given crushed and placed in applesauce or honey thickened liquid. The nurse stated that she always gave medication whole because he would not take it crushed. She was advised that this was not acceptable practice and for Individual #51's medication to be administered safely she must follow the PNMP instructions. She was asked if she had informed the Physical and Nutritional Management Team (PNMT) of Individual #51's refusal to take medication crushed and she stated she had not. The medications were crushed and mixed with honey thickened liquid and were administered without refusal. An observation of Individual #51 found that he had an exaggerated tongue thrust which would have made it difficult and unsafe to receive medications whole. • The nurse consistently documented medications after they were given on the paper MAR but did not consistently document them in the MediMAR electronic record system. See the report below regarding the use of the MediMAR record system. • The daily Control Drug Log was checked for the required double signatures of the on coming and off going nurse shift nurses. There was no double signature found on the Log for the change of the 6-2 to 2-10 shift. The nurse stated she had counted the control drugs with the off going nurse but had forgotten to sign the sheet and promptly signed the sheet. The nurse was informed that it was not acceptable practice to sign the sheet after the fact, that the log must be signed by both nurses immediately after counting the control drugs. The problematic issues identified above were discussed with the CNE, NOO, Nurse Manager, and QA Nurse for corrective action. The nurses must refer to the PNMP contained in the MARs and should not rely on the posted list of special instructions because the list may not be keep current. The CNE immediately sent a notice to all nurses that the PNMP instructions for medication administration must be adhered to. The continued lack of privacy for individuals during medication administration was also discussed with the CNE. She explained that the signs announcing that medication administration was in progress had not been effective and had been discontinued. Neither had the consistent assistance by the direct care professionals to assist the nurse	

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		during medication been successful. This problem was demonstrated earlier in La Paloma. There remained no available private building space for which to administer medication. Another solution for providing privacy was to place tracks on the ceiling in front of the medication room doors to hang privacy curtains. The CNE provided documentation that the tracks and curtains had been ordered but not received. The Monitoring Team will follow-up on this issue at the next review. The Facility continued to require the Nursing Department to use the MediMAR electronic record system as well as use of paper MARs to record medication administration. The same problematic issues were identified as were found at the last review, which included but were not limited to: • The duplicate system increased the time to pass medications. • Often nurses failed 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 presents another problem because the scanned medications were opened and prepared for administration, resulting in pre-pouring medications. Therefore, when individuals returned for their medications, medications cannot be accurately checked with the MAR because they were out of packing and were unidentifiable. This violates safe medication administration practices and can lead to medication errors and risk of harm to individuals. • MediMAR was not capable of scanning all medications. In order to remedy the problems, the paper MARs were printed weekly with the nursing staff instructed to document first on the paper copy in order to ensure that medications administered were consistently and accurately documented. During the medication observations, the nurse did consistently document the administration of medications on the paper MARs but failed to consistently document in the MediMar. The failure to consistently document on the MediMar renders the use of this system useless. It only servers to cause confusion, the potential to continue to contribute to medication errors, and increased time to administer medications. As was recommended at the last review the Facility should evaluate the risks and benefits of continuing the use of the MediMAR electronic record system and ensure a system is in place that is reliably followed, effective at minimizing errors, and efficient. The QA Nurse conducted MAR audits monthly on six records. A Corrective Action Plan was developed, implemented and followed through to resolution for deficiencies identified. A review of the MAR audits for March, April, and May, 2011, and corrective action plans including with supporting documentation when plans were followed	

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		through to resolution. The percentage of compliance found on the audits were: • March – 76% • April – April 73% • May – 77% There were no audit MAR data provided to the Monitoring Team for June, July and August, 2011. There was no explanation given for the missing months of audit data, therefore; it could not be determined whether this audit process was continued. The audit of the MARs was an excellent process for identifying deficiencies, and should be continued; particularly since the audits reviewed found the percentages of compliance less than 80%. Since the last review, it was positive to find the procedure for in reporting and investigating medication errors had been revised. The Nurse Managers will take corrective action upon discovery of the error. The errors will be investigated and entered into the CWS within 5 working days. This was a change from the previous requirement to investigate and enter medication errors into the CWS within 15 working days. A review of the last 10 Medication Error Investigations revealed the following findings: • Ten of 10 (100%) medication errors occurred in El Paisano. • Eight of 10 (80%) medication errors were classified as Category C, i.e., the error reached the individual but did not cause harm. • Eight of 10 (80%) Category C medication errors were reported to the physician. • Two of 10 (20%) medication errors were classified as Category A, e.g., the error did not reach the individual. One was a transcription error caused by the nurse. The other error was due to the failure to include an allergy to Niacin. The record had been labeled by Health Information Management reflecting the allergy and the allergy had been entered in the CWS and was on the MAR but the current Physician Orders indicated no known allergies. A correction was made for allergy to Niacin on the Physician Order's. The physician was not notified of these errors. • Three of 10 (30%) medication errors were not discovered for a month or more. • Eight of 10 (80%) medication errors were not investigated and entered in CWS within five days, as required by the revised procedure. • Ten of 10 (100%) contained documentation that corrective action had been taken for the medication errors. It was of concern that the last 10 medication errors occurred in El Paisano, according to information provided by the Facility. This indicated a potential systemic problem with medication administration practices. The Nursing Department should further investigate and take corrective action to decrease the incidents of medication errors in El Paisano and should ensure reporting from La Paloma is accurate.	

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		Although there was evidence corrective action had been taken for all medication errors, it could not be determined from the 10 Medication Error Investigation Reports whether corrective action was taken at the time of discovery or upon investigation. At least 80% of the medication errors were not discovered for over a month; in some instances it was two or three months. This delay in discovering and correcting medication errors was not acceptable practice. The Nursing Department needs to ensure that medication errors are promptly identified and appropriate corrective action taken to prevent repeated errors. It was positive to find since the last review, that there had been an increase in the number of medication errors reported, because it appeared there had been underreporting. The QA Nurse reported that the raw data showed an increase in medication errors reported. During the first two quarters only two errors were reported. After some training, reminding of the non-punitive medication error culture, and increased auditing of the MAR, there was an increase in the number of medication errors reported. The Facility reported the following medication errors for nursing for the past five months: • March – 8 • April – 6 • May – 11 • June – 6 • July – 5 Medication Errors were not reported for other disciplines. The Facility did not have a Medication Variance Policy. The Facility had two Medication Error Policies, one for nursing (NR 400-12) and one for pharmacy (PH100-017-09). Neither policy addressed all aspects of medication variances. The State Office has a draft Medication Variance Policy that was under review by the respective disciplines. When this policy is finalized and issued to the facilities this should improve the quality of medication administration practices. The QA Nurse stated in the past medication errors were reviewed facility-wide. The Pharmacy and Therapeutic Committee recommended separating the data by service area so the areas could be focused on separately, and analyzed by the respective department for corrective action. In July 2011 the QA Nurse began separating the medication error data for the ICF-MR Facility, from Mental Health Services and Outpatient Clinic. The Facility's plan going forward was to track, analyze and trend medication error data by month/quarter, home, classification, type, cause, contributing factors, medication	

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		involved in the error, and staff committing the error. This data will be entered into CWS, which has the capability to produce reports that represent all aspects of the data, as well as to producing reports in tabular and graphic forms. The QA Nurse had compiled ICF-MR Facility's medication error raw data for the first three quarters of 2011; and it was pending the review of the Nursing Department. The fourth quarter data was pending due to August being the last month of the quarter. Starting in 9/2011, year to year data will be included in the quarterly medication error reports for analysis. Medication error data results were presented to the Medication Error Workgroup for review and analysis. The analysis of the data was presented to the Pharmacy and Therapeutic Committee and at Nursing Meetings. A review of the Nursing Meeting Minutes included some discussion and recommendations for improving medication administration practices. A review of the Pharmacy and Therapeutic Committee Meeting Minutes for March and June, 2011, found that facility-wide (ICF-MR, Mental Health, and Outpatient Clinic) issues were discussed in the meeting with very limited information devoted to the ICF-MR medication administration practices and/or medication errors. The June, 2011 minutes only contained agenda items. The actual minutes were not available for review as requested. A review of the Blood Glucose Monitoring Daily Quality Control Record, found that the glucometers were being check more consistently. The CNE reported a hospital grade glucometer had been ordered. Until the equipment arrives, the purchasing company was lending glucometers. She reported that the company had trained all nurses to use the new glucometers. In order for the Facility to meet compliance with this provision, positive practices identified in the report must be maintained and improvements made in other practices. The Facility should ensure that the following practices are improved: • Afford individuals privacy during medication administration. • Ensure that the nursing staff follows individuals' special medication administration instruction according to their PNMP. • Ensure that quarterly Medication Administration Observations are completed according to schedule, and take immediate corrective action with individual nurses when deficiencies are identified. • Analyze and trend Medication Administration Observation data to identify systemic trends and take corrective action when indicated. • Ensure Nurse Managers who completed Medication Administration Observations demonstrate competency.	

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		• Implement an inter-rater reliability system for Medication Administration Observations. Ensure that all nursing staff are trained in the new Medication Administration Policy developed by the SSLC CNE Workgroup. • Ensure that all nursing staff are trained in the new Medication Administration Policy developed by the SSLC CNE Workgroup. • Ensure that the nursing staff report all medication errors upon discovery and that they notify the Nurse Managers of the errors so they can be immediately investigated and corrective action taken when indicated. • Continue to refine the medication error reporting system/database to track, analyze, trend, and develop corrective action plans. • Evaluate the risk and benefits of continued use of the MediMar electronic record system and ensure a system is in place that is reliably followed, effective at minimizing errors, and efficient.	

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

1. The Nursing Department should make the following improvements in nursing staffing practices: (Provision M.1)
   - Ensure adequate full-time staff nursing positions to provide coverage to eliminate the need to use Nurse Managers, Nurse Case Managers, and agency nurses to make-up the shortage in staffing.
   - The Nurse Manager position should not also double as a Physical and Nutritional Management Nurse because the role and responsibilities inherent in each position requires full-time attention.
2. The Nursing Department should make the following improvements in managing acute illnesses and injuries, and documentation practices: (Provision M.1)
   - Ensure that the nursing staff are competency-based re-trained on Management of Acute Illness and Injury Procedures Nursing Documentation Guidelines, and Pre-treatment and Post-sedation Assessment Protocols.
   - Ensure collaboration with other disciplines in order to provide integrated services.
   - Ensure that the nursing staff notify the Infection Control Preventionist Nurse of all infectious and communicable diseases.
   - Ensure nursing staff document in the Integrated Progress Notes what needs to continue to be monitored, by whom, and the frequency of the monitoring.
3. Infection Control Program should make improvements in the following areas: (Provision M.1)
   - Develop and implement a system for checking the reliability of infectious and communicable disease reports to ensure that all cases are reported timely and completely.
   - Collaborate with the Pharmacy Department to monitor the use of antibiotic prescribing practices within the Facility, and respond with additional training and other interventions as needed.
   - Ensure that a monitoring system is in place to ensure that staff practice Standard Precautions at all times.
4. The Facility should make the following improvements the emergency response system: (Provision M.1)
   - Maintain a Mock Medical Emergency Drill Schedule that also validates that drills were completed as scheduled.
   - Ensure that time is allocated at the Safety/Risk Management/Infection Control Committee Meeting, to adequately review and discuss the results of the Mock Medical Emergency Drills and/or emergency response, develop plans of correction, and follow through to resolution.

- The physicians should participate in the drill unless there is a justifiable reason they could not participate.

5. The Quality Enhancement and Nursing Departments should make the following improvements in the quality enhancement practices (Provision M.1)
   - Develop a plan for more thorough use of tools in conjunction with the QA program at the Facility and with DADS.
   - Ensure Nurse Case Managers completing the monitoring tools are adequately trained on their use, including the tools' guidelines. Emphasis must be placed on evaluating the quality of the nursing care rendered.
   - Quality Enhancement procedures and processes for auditing the Nursing Care: Monitoring Tools should be formalized and refined, particularly for: method used for selecting samples, reliability checks conducted by the QA Nurse, and Corrective Action Plans.
6. The Nursing Department should make the following improvements to nursing assessment practices: (Provision M.2)
   - Ensure that the Nurse Case Managers receive training on how to summarize raw clinical data in Comprehensive Nursing Assessments, Section XI for Nursing Summaries.
   - Develop a standardized format for writing nursing summaries in the Comprehensive Nursing Assessments, Section XI.
   - Ensure Nurse Case Managers include all high and medium risk levels and any other chronic conditions requiring monitoring in the Comprehensive Nursing Assessments, Section X for nursing problems/diagnoses and that care plans are developed and implemented for each problem/diagnosis identified.
7. The Nursing Department should make the following improvements to care plans practices: (Provision M.3)
   - Individualize HMPs and ACPs to address individuals' unique problems and circumstances. Including accurate baseline data regarding the problems and realistic, observable and measurable goals and objectives.
   - HMPs and ACPs should be integrated; developed and implemented in collaboration with other relevant disciplines.
   - The HMP should include criteria for documentation, including the frequency interventions are to be performed, by whom, where documentation is located, how often, and by whom the plans are reviewed.
   - Promptly initiate a HMP and/or ACP when there is a significant change in an individual's health status.
   - HMPs for psychoactive medication should include the name of each medication and their specific side effects and adverse reactions.
   - All identified high or medium risk levels and/or chronic conditions that are unstable or require routine monitoring should have a HMP.
8. The Nursing Department should make the following improvements in nursing training practices: (Provision M.4)
   - Ensure that 100% of the nursing staff are trained on all State nursing policies, procedures, and protocols, as well as in any other required policies, procedures, and protocols refresher training.
   - Implement training from the competency-based Nursing Education Handbook Manual for New Nurse Orientation and refresher training.
   - Ensure that all nursing training is competency-based.
9. The Facility should ensure that the PST receives training on recognizing different types of seizure activity. (Provision M.5)
10. The Nurse Case Managers need to collaborate with physicians and other appropriate disciplines when completing At Risk Screenings to ensure that all relevant medical/health data is collected and accurate for presentation at the PST/At Risk meetings. (Provision M.5)
11. The Facility should make the following improvements in medication administration practices: (Provision M.6)
    - Ensure individuals privacy during medication administration.
    - Ensure that the nursing staff follows each individual's special medication administration instructions according to their PNMP.
    - Ensure that quarterly Medication Administration Observations are completed according to schedule, and take immediate corrective action with individual nurses when deficiencies are identified.
    - Analyze and trend Medication Administration Observation data to identify systemic trends and take corrective action when indicated.
    - Ensure Nurse Managers who completed Medication Administration Observations demonstrate competency.
    - Implement an inter-rater reliably system for Medication Administration Observations.
    - Continue to refine the medication error reporting system/database to track, analyze, trend, and develop corrective action plans.

The following are offered as additional suggestions to the Facility:

1. The CNE or nursing designee should become a standing member on the Safety/Risk Management/Infection Control Committee.

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement, 8/9/11 2. Medication orders for Individuals #5 and #140 3. Medication printout for Individual #5 4. Annual Medication Reviews, Annual Medical Review, Annual Nursing Assessment, and MOSES for Individuals #36, #91, #91, #140, #67, and #12 5. Quarterly Drug Regimen Reviews (QDRRs) for Individuals #36, #19, #91, #140, #67, and #12 6. Incident Management Review Team Meeting minutes, dated 6/20/11 7. Third Quarter Restraint Data, dated 6/20/11 8. Polypharmacy Committee Meeting Minutes dated 8/8/11 and 8/12/11 9. MOSES and DISCUS assessments for Individuals #1, #5, #11, and #19 10. The Facility's Standard Operating Procedure PH100-021-01-02, dated 2010 11. Adverse drug reaction forms for Individuals #33, #31, #15 and #23 12. Minutes from the March, 2011 and Agenda for the June 2011 Pharmacy and Therapeutics (P&T) Sub-Committee meeting 13. Standard Operating Procedure PH100-017-01-09; Medication Error Policy; September, 2001, revised March, 2011 **People Interviewed:** 1. David Moron, MD – Clinical Director 2. Anne Ikponmwonba – Chief Pharmacist **Meeting Attended/Observations:** 1. None
	Facility Self-Assessment: The Monitoring Team reviewed the Facility's Plan of Improvement for Provision N. The Monitoring Team determined that the Facility's plan of improvement for each provision described no meaningful process that would lead the Facility to substantial compliance with the Settlement Agreement. The plan, as outlined, was vague, and offered nothing more that a list of activities completed. The Facility reported it was not compliant with all eight provisions; the Monitoring Team concurred.
	Summary of Monitor's Assessment: Since its last review, the Monitoring Team noted no improvements in the area of pharmacy services. The following is a list of concerns for each provision: N.1: The Monitoring team determined that the Facility had an ineffective mechanism to ensure that pharmacists appropriately review medication orders, and to ensure that each order is associated with a clinically rational diagnosis and appropriate dosage range; that side effects and allergies are addressed; and that necessary laboratory testing is accomplished. In addition, the Facility made a critical omission of

	processing an order for Coumadin; there was no process in place to detect such significant errors of processing. The Monitoring Team determined that the Facility is not in compliance with Provision N.1, of the Settlement Agreement. The Facility must address these issues before compliance will be achieved. N.2: Based on significant clinical findings, and an ineffective QDRR process, the Monitoring Team determined the Facility to be not in compliance with the Provision. N.3: The Facility did not have a comprehensive system in place that enables collaboration between the pharmacist and prescribing medical practitioners when addressing STAT medications, benzodiazepines, anticholinergics and polypharmacy. The Monitoring Team determined the Facility not to be in compliance with Provision N.3, of the Settlement Agreement. The Facility must enhance its process to monitor collaboratively these medications.. N.4: The Monitoring Team determined that the QDRR process at the Facility was inadequate, and that the Facility was not in compliance with Provision N.4, of the Settlement Agreement. The Facility must develop a consistent and functional process that ensures physicians address pharmacists' recommendations, establish a protocol to follow when physicians and pharmacists do not concur on a clinical issue, establish a mechanism to document collaboration between pharmacists and physicians, and ensure that recommendations are followed-up to resolution. N.5: Because the MOSES and DISCUS assessments were not completed as required, and because more frequent monitoring for Tardive Dyskinesia (TD) is not assessed when clinically indicated, the Monitoring determined that the Facility remained not in compliance with Provision N.5, of the Settlement Agreement. The Facility must enhance its efforts by ensuring appropriate completion of the MOSES and DISCUS, that they provided more frequently when needed, and that abnormal findings are appropriately addressed. N.6: The Facility's Adverse Drug Reaction process (ADR) was determined not to be effective in addressing adverse drug reactions at the Facility. The Facility's policy for ADRs was not adhered to, and the ADR forms were not completed as required. There was no meaningful review process for ADRs. The Monitoring Team determined that the Facility remained noncompliant with Provision N.6. The Facility must address concerns raised in Provision N.6 before compliance can be determined. N.7: The Monitoring Team determined that the Facility's Drug Utilization process provided some information to providers regarding prescribing habits for selected medications. The process did not enable drugs not on the Facility's DUE list to be reviewed, and there was no process to assess drug utilization when the FDA and/or the Manufacturer issues an alert or warning. The Monitoring Team determined that the Facility remains not in compliance with Provision N.7, of the Settlement Agreement. N.8: The Monitoring Team reviewed the updated DADS Policy for Medication Errors, and determined that it contained the essential elements of a Medication Variance Process, and if implemented would help enable the Facility's compliance with Provision N.8. The Facility intends on adopting the new policy in the near

	future. Because the Facility had yet to implement the DADS Medication Error Policy, the Monitoring Team determined the Facility not to be in compliance with Provision N.8, of the Settlement Agreement.

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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 met with the director of pharmacy service, at the pharmacy, to discuss and observe how pharmacists reviewed medication orders, and ensure that each order is associated with a clinically rational diagnosis and appropriate dosage range; that side effects and allergies are addressed; and that necessary laboratory testing is accomplished. There was no documentation, such as a procedure, that delineated how the pharmacist is expected to review the orders. The Facility had established its own record system that was intended to maintain a record for each individual, for the purpose of documenting issues related to pharmacy interventions and medication order reviews. There was no written procedure that outlined this process, and upon review, the Monitoring Team was unable to substantiate consistency of the record system. Upon review of pharmacists' entries into the WORx program, and review of the individual record system maintained at the pharmacy for Individual #5, the Monitoring Team noted significant issues. First, a prescription was written on August 3, 2011 for Coumadin, 10 mg orally for one dose, then 7.5 mg on Friday and Wednesday, and 5 mg every other day, and to check PT/INR in three days. According to the review of the WORx program, and following discussion with the pharmacy director, who signed off on the order, the order for Coumadin on August 3, 2011 was not processed timely, and the individual did not receive the Coumadin, 10mg dose, as prescribed. Second, there was no documentation on the part of the pharmacist with regards to subtherapeutic drug levels noted on August 11, 2011, and July 26, 2011. Also, the pharmacy order written on August 3, 2011, did not list allergies, and the WORx database indicated that the individual had an allergy to Augmentin. An order for Individual #140 was written on August 11, 2011 and the order form did not have the allergy component completed. The individual was reported to be allergic to Metoprolol. No documentation was found noting discussion by the pharmacist with the prescriber on ensuring that allergies are noted on the order form. The Monitoring team determined that the Facility had an ineffective mechanism to ensure that pharmacists appropriately reviewed medication orders, and to ensure that each order is associated with a clinically rational diagnosis, appropriate dosage range, and that side effects, allergies and the need to assess laboratory testing were accomplished. In addition, because of a critical omission of processing an order for	Noncompliance

#	Provision	Assessment of Status	Compliance
		Coumadin, the Monitoring Team determined that the Facility is not in compliance with Provision N.1, of the Settlement Agreement.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	Provision N2 requires that the Quarterly Drug Regimen Reviews ensure that the pharmacist takes into consideration laboratory results during the review process. The Monitoring Team reviewed the following cases and noted that laboratory results were not routinely utilized, as clinically indicated: The Quarterly Drug Regimen Review (QDRR), and Annual Medication Review, for Individual #36, were reviewed by the Monitoring Team. The Annual Medication Review dated 7/20/11, indicated that the individual was on both olanzapine (for psychosis), and Seroquel (for agitation and mood). The QDRR noted that the individual has sustained multiple falls and attributed this to the addition of Seroquel, and no other drug was entertained as possible contributors, despite being on significant polypharmacy that included lithium, olanzapine, Seroquel, valproic acid, and benztropine. Neither the QDRR nor the Annual Medication review commented on drug levels for valproic acid, or lithium levels. The QDRR and Annual Medication Review for Individual # 140 was reviewed by the Monitoring Team. No specific laboratory values were documented or commented on within the context of the QDRR. The individual had an Axis I diagnosis of Schizoaffective disorder, bipolar type. Neither the QDRR nor Annual Medication reviews commented on the individual's active diagnosis of seizure disorder, while being prescribed clozapine. Clozapine is known to significantly lower the seizure threshold and predispose some people to increase seizure frequency, in addition to considering the risk of clozapine and the individual's increased seizure activity, Although it is not a standard of practice to get clozapine levels, that information might have assisted in better management of this particular case. Clozapine levels were not obtained or recommended by the pharmacist. At a minimum, the pharmacist should have pointed out the issue of the effect of clozapine on seizure threshold and recommended the physician review and make an explicit decision on changes in use or dosage of either clozapine or antiseizure medication. It was noted by the pharmacist that the individual was at risk for metabolic syndrome, however, the pharmacist did not comment about this risk as part of the QDRR and Annual Medication Review recommendations, and more close laboratory follow-up was not considered. The Monitoring Team reviewed the QDRR and Annual Medication Reviews dated July 20, 2011 for Individual #19. The QDRR listed the first name first, while the Annual listed the last name first. The Monitoring Team has observed this type of clerical issue on other documents, and it can lead to adverse outcomes.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The individual is on both lamotrigine and valproic acid, among other medications. No laboratory values were documented. There was no comment to the physician about the need to closely monitor drug levels when both lamotrigine, and valproic acid are coadministered, nor the additional risk for Stevens John Syndrome, which is a potentially life threatening condition. There was no evidence to support that the physician reviewed and concurred with recommendations. There was a diagnosis of skin rash, and the pharmacist did not question the coadministration of lamotrigine and valproic acid, which carries additional risk for a significant condition for which skin rash is a possible sign. Per review of the QDRR, the individual was noted to be at risk for Metabolic Syndrome; however, this was not reported as a pharmacist's recommendation, hence the treating physician was not alerted to this condition, and additional laboratory monitoring for metabolic syndrome was not obtained. The Monitoring Team had significant concern about the overall quality of QDRR reviews by the Facility. Not only were drug levels not appropriately documented, many clinical issues where not addressed, per review of the documents provided. There was no documentation to determine if the physician agreed or disagreed with the pharmacists' recommendations, nor was there a mechanism to ensure that physicians followed the recommendations The Monitoring Team reviewed the QDRR, and Annual Medication Review for Individual #91, dated 7/20/11. The individual was prescribed alendronate for the indication of osteoporosis; however, the diagnosis listed on the Annual Medication Review, the Medical Evaluation Review dated 12/23/10, and Nursing Assessment dated August 28, 2011, did not list osteoporosis as a diagnosis. Also, neither the QDRR, the Annual Medication Review, nor the Nursing Assessment or Medical Evaluation commented on a diagnostic evaluation to determine the cause of osteoporosis, prior to starting treatment. It is important to rule out reversible causes of osteoporosis, prior to initiating treatment. It is also important to monitor diagnostic and clinical findings during treatment with Osteoporosis, which were not documented as part of the QDRR process. There was no indication that the physician reviewed and/or followed the pharmacist's recommendations. The Individual was noted to be at risk for Metabolic Syndrome, but this was not included as a recommendation by the pharmacist. The QDRR did recommend the need to monitor prolactin levels; however, the Annual Medication Review did not recommend the need to monitor the levels. The Monitoring Team determined that the Facility did not have an effective QDRR process in place. The pharmacists did not document important laboratory and other diagnostics, specific to medications that require monitoring. Potentially serious issues, such as not identifying an individual with a skin rash while on valproic acid and lamotrigine, and not commenting on the concern for seizure exacerbation for an	

#	Provision	Assessment of Status	Compliance
		individual on Clozaril with seizure disorder, are of serious concern and do not meet standard of care practice when conducting a comprehensive Clinical Pharmacy Review. Listing inaccurate diagnoses and omitting diagnoses on the Annual Medical Review, and having multiple diagnoses for the same medication are also of concern. The QDRR and the Annual Medication Review Process did not appear to be well thought out or comprehensive. There was no process in place to ensure physician review, nor was there consistent evidence that recommendations were attended to and followed-up by the physician. For these reasons, the Monitoring Team concluded that the Facility is not in compliance with Provision N.2, of the Settlement Agreement.	
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 Monitoring Team was informed by the Director of Pharmacy Services that the use of STAT medications and chemical restraint are reviewed by the Incident Management Team Meeting. Upon review of the minutes for the meeting, the only practitioner present was a single primary care provider. Neither a psychiatrist, Clinical Director, Medical Director or a pharmacist was present. The Facility did track the use of chemical restraint by incident and conducted a trends analysis; however, the minutes did not reflect a discussion on the incidences of emergency restraint, but only reflected that two individuals required emergency restraint. Nevertheless, the use of emergency restraint at the Facility was not excessive . Review of QDRRs for Individuals #36, #19, #91, and #140 indicated that the pharmacist was assessing for Metabolic Syndrome; however, when identified as a risk factor, the issue was not addressed as a recommendation, and there was no clinical plan developed to address the issue. For individuals diagnosed with osteoporosis (an endocrine/metabolic condition) and treated with medications, the pharmacist did not comment on the QDRR about medication risk factors for osteoporosis and the need for a baseline evaluation to determine the underlying etiology. The Monitoring Team was informed that the Facility addresses the use of benzodiazepines in the context of the QDRR process and the Polypharmacy Committee Meeting. During discussion with the Clinical Director, the Monitoring Team was informed that the Polypharmacy Committee was recently launched in July, 2011. At the time of this review, the committee had only focused on developing a list of individuals who are noted to fall under the category of polypharmacy. Polypharmacy Committee Meeting minutes of 8/8/2011 and 8/12/11 did not reflect meaningful discussion of anticholinergics or benzodiazepines. The Clinical Director was not present for either meetings. Importantly, there was no data analysis or process in place to ensure the review of longitudinal data of the use of anticholinergics, and benzodiazepines. At the time of this review the Facility did not have a comprehensive system in place to	Noncompliance

#	Provision	Assessment of Status	Compliance
		ensure the pharmacist and prescribing medical practitioners collaborate in monitoring the use of STAT medications and chemical restraint; 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 new generation antipsychotic medications. For these reasons, the Monitoring Team had determined that the Facility remains not in compliance with provision N.3, of the Settlement Agreement.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Review of QDRR and Annual Medication Reviews for Individuals #67, #12, #36, #19, #91, and #140 did not find evidence of review by a physician. The documents were not completed and signed, as required. There was one "Single Patient Intervention Report" referred to the Monitoring Team for review. This report was for Individual #2. The Single Patient Intervention Report, dated 8/9/11, indicated that Milk of Magnesia was as an unnecessary medication because the individual was also on Colace. The pharmacists documented advising the "MD to discontinue MOM. Will monitor bowel movements." The Pharmacy Intervention Review form that was provided to the Monitoring Team indicated a physician response agreed with the pharmacists; however, the physician did not sign or date the document, nor were orders for more frequent bowel monitoring identified. On 8/16/11, an order for Milk of Magnesia was issued for constipation, and later that day, an additional order for Miralax was ordered for constipation – indicating a significant recurrence of constipation. Review of the individual's QDRR, dated 5/16/11, documented a pharmacist's comment to "pls, monitor liver panel closely, ALT > 2 x unl" on 3/8/11, and also recommended "if pt was not given Hepatitis B vaccine, pls. consider administration." The physician documented a response to this particular QDRR. The pharmacist recommendation to administer Hepatitis B vaccine was questioned by the Monitoring Team as it is essential first to fully understand the underlying etiology of the elevated liver enzymes, prior to administering vaccine. For these reasons, the Monitoring Team Determined that the Facility is not in compliance with N.4, of the Settlement Agreement. The Facility must develop a consistent and functional process that ensures physicians address pharmacy recommendations, establish a protocol to follow when physicians and pharmacists do not concur on a clinical issue, establish a mechanism to document pharmacist and physicians collaboration, and ensure that recommendations are followed-up to resolution.	Noncompliance
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 and DISCUS assessments were reviewed for completeness for Individuals #1, #5, #11, and #19. The following is a summary of the Monitoring Teams findings: Individual #1: MOSES: 7/11/11 was completed by the nurse on 7/11/11, and signed by the physician	Noncompliance

#	Provision	Assessment of Status	Compliance
	MOSES or DISCUS), of tardive dyskinesia.	on 7/19/11. The physician did not complete the prescriber review. Individual #5: DISCUS: 8/14/11 was completed by the nurse on 8/14/11, and noted to have increase in severity from four to five total score. The physician reviewed the DISCUS on 8/15/11 but did not complete the prescriber component of the DISCUS, and did not comment on the increase in severity. Individual #11: MOSES was initiated by the nurse on 4/20/11 but only the vital signs were documented, while the assessment was not completed. The physician signed the MOSES on 4/26/11, and indicated that no action was necessary, despite the MOSES not being completed (this issue was verified by the Monitoring Team by direct review of the copy in the clinical record and discussion with staff). MOSES: 1/31/11 was competed by the nurse on 1/31/11 and signed by the physician on 2/1/11; however, the prescriber review was not completed. MOSES 2/25/11 was completed by the nurse on 2/25/11 and signed by the physician on 2/28/11; however, the prescriber review was not completed. Individual #19: DISCUS was initiated by the nurse on 2/3/11; however the nurse did not complete the evaluation component of the DISCUS. The physician signed the DISCUS on 2/28/11, twenty-five days after the nurse referred the DISCUS for physician review. Also, the physician did not complete the conclusion of the DISCUS. During its review of clinical records on-site, the Monitoring Team did not identify assessments for side effects more regularly then routinely scheduled. For example, whenever there is a dose change of a medication that can affect the blood levels of an antipsychotic, or in the event of behavioral and/or functional changes, more frequent assessments for side effects should be obtained. The Facility must also ensure a mechanism to follow-up on abnormal findings identified by the assessments. Because the MOSES and DISCUS assessments were not completed as required, and because more frequent monitoring for Tardive Dyskinesia (TD) was not done more frequently when clinically indicated, the Monitoring Team determined that the Facility remained not in compliance with Provision N.5, of the Settlement Agreement.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely	To assess compliance with Provision N.6, of the Settlement Agreement, the Monitoring Team requested the Facility's local policy for Adverse Drug Reactions (ADRs), Drug Reaction Form, minutes for the past six months from P&T and Medical Staff Meetings that indicate review of ADRs, a list of all ADRs since past six months, and copy of all data	Noncompliance

#	Provision	Assessment of Status	Compliance
	identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	and trends analysis used to assess ADRs. The Monitoring Team was informed that the Facility did not assess data, nor did they consider trends analysis of ADRs, during their reviews. The Facility reviews ADRs at the P&T Sub-Committee Meetings. Minutes from the March 2011 meeting were provided. Minutes from the June, 2011 meeting were not completed at the time of this request; hence, they not available for review. Copies of four ADRs, for Individuals #15, #31, #33, and #23, were provided for reviewed. Minutes from the March 2011 P&T Sub-Committee Meeting were reviewed. The Monitoring Team had participated at that meeting during its previous review. The minutes reflected that no ADRs were reported at that time. No further discussion was noted. The agenda for the June, 2011 P&T Sub-Committee Meeting was reviewed, but the Monitoring Team could not assess functionality of the review process because minutes were unavailable. The Facility's Standard Operating Procedure PH100-021-01-02; Adverse Drug Reaction Report And Evaluation Form; dated December 1, 1995 was reviewed by the Monitoring Team. The procedure had been reviewed on March 2011. The Procedure did outline the process for completion of the ADR form; however, it noted that Quality Management was to review the completed forms. The Facility's new process, which has not been documented, assigns the P&T Sub-Committee to review reported ADRs. The Procedure did not comment on P&Ts Subcommittee role. Data, specific to the type of ADR, suspected or known cause of the ADR, the individual's demographics, prescriber, noted adverse outcome, and actions taken should be collected longitudinally on all ADRs and periodically reviewed. Review of the following ADRs was conducted by the Monitoring Team: • Individual #33: Was noted to be undated; was initiated by the nurse; the Physician did comment on the physician's section of the report; however the Medical Staff Committee Review did not complete their section. • Individual #31: Was noted to be undated; was initiated by the nurse; the Physician and Medical Staff Committee did not complete their sections. • Individual #15: Was noted to be undated; was initiated by the nurse; 4/18/11 date was handwritten behind the nurses name; the Physician and Medical Staff Committee did not complete their sections. • Individual #23: Was noted to be undated; was initiated by the nurse; was not completed by the Physician or the Medical Staff Committee. The Facility's ADR process was noted by the Monitoring Team to be ineffective. The Facility's procedure was not updated to reflect the Facility's practice of involving the P&T Sub-Committee. There were no minutes available for review to assess how the Facility	

#	Provision	Assessment of Status	Compliance
		reviews ADRs. Completed ADR forms provided to the Monitoring Team were incomplete and did not require persons completing the document to provide dates. The Facility did not collect important data that would be considered necessary during a systems review of ADRs. There was no process to provide an overall summary of the ADR event. There was no process that enables direct care staff the ability to comment on the ADR. There was no process to educate staff on signs and symptoms of ADRs. For these reasons, the Monitoring Team determined the Facility to be not in compliance with Provision N.6, of the Settlement Agreement.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Monitoring Team reviewed the Facility's Medication Alert Criteria and Guidelines for conducting Drug Utilization Evaluations (DUEs) and completed DUEs for June, 2011. The Monitoring Team requested all graphs, trends analysis and available data used to track DUEs; however, the Facility reported it did not collect data for their DUE process. The Facility conducted DUEs very differently from other facilities reviewed by the Monitoring Team. Based on their Guidelines, the Facility selected drugs to regularly monitor and ensure that appropriate laboratory monitoring is completed as needed. Each of the 33 drugs identified had a corresponding list of issues that must be considered during the DUE review. Each quarter, the pharmacist reviewed all individuals who were prescribed one or more of the selected drugs, and documented findings on the Drug Audit Checklist 19. Data from the Drug Audit Checklist 19 form was then entered into a spreadsheet The Facility had no mechanism in place to readily provide additional DUEs that may be needed to address FDA and Manufacturers alerts and warnings, or when an unusual or unexpected adverse outcome develops. There was no mechanism to provide education or remediation of staff base on information gained by the DUE. The Facility's Guideline did not indicate the need for DUEs to be summarized and reviewed by a professional body at the Facility. Data were not collected on the DUE process. The Facility's DUE process must be enhanced to ensure that DUEs are provided beyond the scope of their current guideline. DUEs must be readily provided when unusual and unexpected outcomes are noted at the Facility, and when the FDA and/or Manufacturer issues alerts and warnings. Longitudinal data on DUEs should be collected for trends analysis. Educational venues should be developed for staff, including physicians, nurses, pharmacists and direct care providers on issues related to the DUE. The guideline for DUEs at the Facility should reflect the actual process conducted by the Facility. A professional review body should oversee the DUE process, and be responsible for reviewing outcomes from DUEs. Recommendations stemming from a DUE should be periodically reviewed to ensure that they are incorporated into the Facility's practice standards. For these reasons, the Monitoring Team determined that the Facility is not in	Noncompliance

#	Provision	Assessment of Status	Compliance
		compliance with Provision N.7, of the Settlement Agreement.	
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.	At the time of this review, the Facility was in the process of adopting the DADs Medication Error Reporting Policy. The Director of Pharmacy and Clinical Director informed the Monitoring Team that they had yet to implement the new policy; however, they plan to implement it prior to the next review period. The Monitoring Team requested and obtained the DADs Standard Operating Procedure PH100-017-09; Medication Error Policy, dated September 2001, revised March 2011. The Monitoring Team determined its utility, and recognizes if appropriately implemented, it would help enable compliance of Provision N.8 of the Settlement Agreement. The Monitoring Team noted a few minor issues with the new Policy: 1. Medical leadership was not included under applicability of the procedure. 2. There did not appear to be an overarching review body that is responsible for the medication variance process. Medication variances must be carefully analyzed, and reported on. 3. Although Risk Management reports to the Pharmacy, and Director of Nursing, they do not report prescribing concerns to the Clinical Director. 4. The Facility leadership should regularly be made aware of longitudinal analysis of medication variances at the Facility. In general, the Medication Error Policy contains essential elements that will help enable the Facility to develop a robust, and meaningful Medication Variance Program. Because the Facility had not implemented the new Medication Error Policy, the Monitoring Team noted that the Facility did not have a functional Medication Variance Process in place at the time of this review, and determined that the Facility is not in compliance with Provision N.8, of the Settlement Agreement.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:
1. If the Facility continues to maintain a separate "folder" to maintain clinical information at the pharmacy, the Facility must ensure that the process has appropriate policies and procedures in place for this function.
2. Ensure that all prescriptions are processed timely and completely.
3. The QDRR process is ineffective and must be reviewed and enhanced. The Monitoring Team recommends seeking technical assistance. Issues needing to be addressed include documenting of relevant laboratory data, ensuring accurate diagnosis are in place, following up on potentially serious drug related issues, making sure that the physician reviews and addresses the pharmacist's concern, and ensuring that recommendations are followed by the physician.

4. The Facility must develop a consistent and functional process to ensure that physicians address pharmacy recommendations, establish a protocol to follow when physicians and pharmacists do not concur on a clinical issue, establish a mechanism to document pharmacist and physicians collaboration, and ensure that recommendations are followed-up to resolution
5. Ensure that all side effect screening assessments for TD are completed appropriately, reviewed, and signed timely by the physician, and completed more frequently when clinically indicated.
6. Update the written Facility procedure for ADRs to reflect the Facility's practice.
7. Ensure that all direct care staff are aware of ADRs and how to identify signs and symptoms of ADRs, and that all staff are enabled to report ADRs.
8. Ensure that relevant data (as outlined in Provision N.6 of this report) are collected, analyzed and reviewed, when reviewing system issues related to the ADR review process.
9. Ensure that all forms used for ADRs are dated and completed.
10. Ensure the review process for ADRs, through the P&T Sub-Committee, or other venue, assesses root cause analysis of ADRs and does not simply record that an ADR occurred.
11. The DUE Process must be enhanced.
12. The Facility must implement the DADs Policy for Medication Errors

The following are offered as additional suggestions to the Facility:

1. It would be advantageous to develop a peer review process for pharmacy staff, especially to review and determine appropriateness of recommendations made on QDRRs, Annual Medication Reviews and Pharmacy Interventions.
2. It would be advantageous if the DADs policy for Medication Errors included the following:
    a. Medical leadership should be included under applicability of the procedure.
    b. There should be an overarching review body that is responsible for the medication variance process. Medication variances must be carefully analyzed, and reported on
    c. Although Risk Management reports to the Pharmacy, and Director of Nursing, they should also report to the Clinical Director.
    d. The Facility's Superintendent should be made aware of longitudinal analysis of medication variances at the Facility.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Plan of Improvement (POI), dated 8-9-2011 2. Record reviews: a. Sample 1: Individuals #19, #47, #54, and #134 b. Sample 2: Individuals #1, #15, #21, #51, #58, #80, and #94 c. Sample 3: Individuals #47 and #126 d. Sample 4: Individuals #21, #27, #36, #62, #72, #79, #113, and #150 3. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials 4. A list of continuing education sessions or activities participated in by PNMT members since last review (3/2011) 5. Minutes, including documentation of attendance, for the PNMT meetings for the past 6 months 6. Individual PNMT reports as available for individuals reviewed above 7. Tools used to screen and identify individuals' PNM health risk level 8. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order 9. Tools used to assess PNM status and needs 10. A list of PNM assessments and updates completed in the last two (2) quarters 11. PSPs for the sample individuals 12. Completed Physical Nutritional Management Plans (PNMPs) for all sample individuals 13. Tools used to monitor implementation of PNM procedures and plans 14. 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 15. Nutritional management plan template and any instructions for use of template 16. Dining Plan template 17. PNM spreadsheets generated by the Facility 18. Training records that occurred in response to diet downgrades 19. Lists of individuals: a. On modified diets/thickened liquids; b. Whose diets have been downgraded (changed to a modified texture or consistency) during the past 12 months; c. With BMI equal to greater than 30; d. With BMI equal to less than 20; e. Since April 2011, people who have had unplanned weight loss of 10% or greater over six (6) months; f. During the past 6 months, have had a choking incident; g. During the past 6 months, have had a pneumonia incident;

	h. During the past 6 months, have had skin breakdown; i. During the past 6 months, have had a fall; j. During the past 6 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 20. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation since the last review 21. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials 22. Tools and checklists used to provide competency-based training addressing: a. Foundational skills in PNM; and b. Individual PNM and Dining Plans 23. Since the last review, a list of competency-based training sessions addressing foundational skills in PNM **People Interviewed:** 1. Jane Augustine PT Director of Habilitation Services 2. Belinda Lopez SLP 3. Elda Hernandez OTR 4. Betty Perez Rehab Tech II 5. Janie Villa and all QDDPs 6. Four direct care staff (2 La Paloma and 2 El Paisano) **Meeting Attended/Observations:** 1. PNMT meeting 8-22-11 2. At risk Meeting for Individual #80 8-22-11 and Individual #40 8-24-10 3. La Paloma lunch and dinner 4. El Paisano lunch and dinner 5. Las Paloma and El Paisano transition times
	Facility Self-Assessment: RGSC Plan of Improvement, updated 8/9/2011, provided comments/status for Sections O.1 through O.8 of the Settlement Agreement. The Facility indicated it was in noncompliance with Provisions O.1, O.3, O.4, and O.6 and in compliance with Provisions O.2, O.5, O.7, and O.8. This was inconsistent with the Monitoring Team's findings as all provisions were found to be noncompliant. RGSC stated that Provision O.2 was in compliance due to the implementation of dining plans that showed adaptive equipment and positioning and the use of the quarterly meeting to provide referrals and increased review by the PNMT. The Monitoring Team found O.2 to be in noncompliance due to lack of a comprehensive PNMP, inconsistencies between the dining plans and other plans of care, and lack of timely discussion in response to a significant PNM event.

	Provision O.5 was found to be in compliance by RGSC due to competency based training being provided at NEO but the Monitoring Team was not in agreement with this finding. Lack of competency based training for all aspects of PNM and lack of a system to ensure pull staff were provided with training prior to working with individual who were at an increased PNM risk. Provision O.7 which covers monitoring was found to be in compliance by RGSC but was found to be not in compliance due to the lack of a thorough review process of individuals who were at the at an increased risk as well as the review of individuals who returned from the hospital with a significant PNS event. Provision O.8 was found by RGSC to be in compliance but was found by the Monitoring Team to be not in compliance due to the lack of investigation into potential pathways to oral intake (i.e., oral musculature exercises and stimulation to improve oral and pharyngeal phase functioning). Other areas of noncompliance will be discussed generally in the Monitors' Assessment and in more detail under each provision. This document also provided a summary of some of the action plans on which the Facility was working to achieve compliance. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the eight provisions but did not provide a clear sequential framework in which they expected to reach compliance. While statements were present regarding general status, there was limited to no data provided to back up substantial compliance claims. The current format merely listed activities, but did not present an understanding of the steps and strategies required to meet the provisions with timelines of completion, which would offer more of a roadmap for all staff and a means to direct their focus, effort, and energy.
	Summary of Monitor's Assessment: **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 in a timely manner 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. **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 and implemented; however, lack of use of clinical judgment and critical thinking when the PSTs had to move beyond the guidelines often resulted in inaccurate assignment of risk. Individuals were not provided with comprehensive assessments in response to changes in status or as part of an annual assessment due to often referring to outdated tests and external assessments. 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.

	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. **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. **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. **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. **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. **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. 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. Positives noted during the review included assignment of a PNM nurse to the PNMT; however, as of this review the nurse was assigned only 20 hours per week and had not been relieved of any of her other duties as a nurse manager at La Paloma. Also noted was increased frequency of meetings of the PNMT to twice monthly but as stated in Provision O.1 the frequency needs to further increase in order to meet the needs of the individuals. Progress was also noted regarding to the development of a PNMT evaluation. The template was reviewed by the Monitoring Team and had the potential to serve the team well by providing detailed information regarding the individuals' total PNM status.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional 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,	RGSC had developed a Physical and Nutritional Management Team (PNMT). The team consisted of an Occupational Therapist (OT), Physical Therapist (PT), Speech-Language Pathologist (SLP), Nurse (RN), Dietitian (RD), Qualified Mental Retardation Professional (QMRP), Rehabilitation Tech (RT) and Food Service Manager. In addition to the listed core members, ancillary members such as Psychology may be requested as indicated. Members of the PNM team included: • Jane Augustine PT • Belinda Lopez SLP • Elda Hernandez OTR • Marcy Valdez RN • Janie Villa QDDP • Andrea Zuniga Food Service Manager • Edith Partin RD PNM Team attendance records and meeting minutes from 03/22/2011 to 8/3/2011 documented sporadic attendance by PNM Team standing members (as defined in RGSC policy). • RN attended 6/7 (85%) meetings • MD attended 2/7 (28%) meetings • SLP attended 6/7 (85%) meetings • OTR attended 5/7 (71%) meetings • Food Service manager attended 5/7 (71%) meetings • RD attended 6/7 (85%) meetings • QDDP attended 5/7 (71%) meetings The makeup of the PNMT was not in compliance with standards set forth by the Settlement Agreement due to the lack of consistent participation by an MD when there was a clear medical component discussed at the meeting. Per report, Dr. Partin MD will assume the role of the PNM physician therefore this element will have to be reviewed during the next compliance visit. Additionally, due to the high frequency of behavior associated PNM issues, the presence of a psychologist as a permanent member would be appropriate. Review of documentation of PNM clinical instruction submitted revealed three opportunities to participate in trainings relevant to increasing their knowledge of PNM. The three courses offered focused on Normal/Abnormal Development, Developmental Disabilities, and Food Texture and Consistency. Per review of sign in sheets, participation of PNMT members were as follows: • PT attended 3/3(100%) offered trainings	Noncompliance

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	or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	• RN attended 3/3 (100%) offered trainings • OT attended 2/3 (66%) offered trainings • SLP attended 0/3 (0%) offered trainings • RD attended 2/3 (66%) offered trainings • QDDP attended 0/3 (0%) offered trainings • Food Service Manager attended 0/3 (0%) offered trainings • MD attended 0/3 (0%) offered trainings • Ancillary members attended 0/3 (0%) offered trainings Due to the importance of PNM, continuing education in the field of PNM should be mandatory for all members of the team. This training should extend beyond the trainings provided by central office or in house staff. Frequency of the PNMT meetings started as monthly then increased to two times per month and was scheduled to increase to weekly. Other than the state policy, the Facility had not developed a localized PNMT policy that defined the roles and responsibilities of the PNMT and the collaboration that was intended to occur with the Personal Support Team (PST). There was not a defined criterion that stated what incidents must be referred to the PNMT and what may be referred to the PNMT. There also was not a QA component to the PNMT in which data relevant to physical and nutritional supports are reviewed and analyzed by the team. Reviewing and identifying trends and the root cause of these trends will allow the PNMT to streamline and pinpoint trainings and/or assessments in an effort to prevent future occurrences, as well as identify other improvements and corrective actions that should be addressed. PNMPs were not in alignment with current best practice standards. For issues related to this component, please refer to provision O.3. PNMPs were not clearly developed with input from all members of the PST or reviewed consistently by the PST. For examples, please refer to provision O.3.	
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	Individuals for sample #1 were chosen from the list of individuals who were diagnosed with an aspiration and/or choking event over the past 6 months. The sample consisted of four individuals who accounted for 100% of the individuals who experienced an aspiration or choking event. Sample #2 consisted of six individuals who were chosen from a list provided by RGSC of	Noncompliance

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	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.	individuals who were identified as being at an increased risk of choking or aspiration. The sample was chosen by choosing every third name on the aspiration/choking at risk list. Sample #3 consisted of 100% of the individuals (two) who received enteral nutrition. Sample #4 consisted of 100% of individuals (eight) who experienced a change in their diet texture over the previous 4 months. Based on a review of 12 individuals' (sample #1, #2, and #3) most recent OT/PT and SLP assessments, zero of 12 Individuals (0%) were provided with a comprehensive assessment by the PNM team that focused on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake. The swallowing components of the Speech assessment were vague, did not provide consistent measurable data or referenced an outdated Modified Barium Swallow Study (MBSS). For example: • Individual #15, #19, #51, and #54's assessment referenced swallow studies that were conducted ranging from 2 months to 9 months in the past. • Individual #1 had not received a swallow assessment. A swallow study that is beyond thirty days may be referenced as a portion of evidence based assessment but cannot be used as the sole assessment due to potential inaccuracies secondary to the length of time since the report. The Oral Care and Medication Administration sections of the OT/PT assessment were vague and contained a general statement of positioning but did not contain any information indicating assessment of the areas. For example: • Individual #21's oral care section stated "staff to assist: but did not provide information regarding how staff was to assist and what assessment determined the level of assistance. • Individual 19's medication administration section stated "crush medication and use maroon spoon" but again there was no evidence of assessment. A comprehensive PNMT evaluation had been developed and was awaiting approval by central office. The PNMT in its format appeared to be comprehensive in that it covered: • Risk factors • Medication side effects • Oral motor assessment	

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		• Nutritional indicators • GI issues • Review of past assessments • Hospitalizations • Surgical procedures • Physical assessment • PNM analysis and recommendations The above was just a template and whether or not the assessment will be sufficient to comprehensively address PNM issues will rely heavily on how well the assessment will be completed by team members. While the function of adaptive equipment was included in the assessments, zero of 12 (0%) (Sample #1, #2, and #3) assessments reviewed contained the link between a piece of equipment and the decline in function in which it was intended to address. For example: • Individuals #1's OT/PT assessment stated that a built up handle spoon assisted with grasp but did not mention the etiology or cause of the decreased grasp. Based on a review of 12 (samples #1, #2, and #3) records of Individuals who experienced an aspiration or choking event and/or were noted by the Facility to be at an increased risk of aspiration and choking, 7 of 12 (58%) records reviewed accurately identified individuals who are at an increased risk of physical and/or nutritional decline. Examples of individuals not being appropriately identified include: • Individual #19 and #54 were identified as being at a "medium risk" of aspiration but per guidelines should have been listed as a "high risk." The PST had the ability to lower the risk; however, there was no evidence of the rationale behind the lower risk score. • Individual #51 as per MBSS was diagnosed with severe oral and pharyngeal dysphagia but was listed as being at a medium risk of aspiration and choking. Lack of critical clinical thinking and discussion was noted when the PSTs had to move beyond the guidelines. This lack of clinical judgment impacted the risk scores and increased the likelihood of inadequate supports being provided to the individual. An example was Individual #51 who was noticed with poor posture during dining and had a diagnosis of severe oral and pharyngeal dysphagia but was listed as "medium risk" of choking and aspiration. More information regarding the identification of risk may be found under section I.	

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		Zero out of four (0%) individuals who were diagnosed and hospitalized with a PNM issue (sample #1) were assessed by the PNMT or PST. For example: • Individual #54 was diagnosed with aspiration pneumonia on 4/21/11 but there was no evidence of reassessment upon return or discussion of the event by the PST. There was discussion by the PNMT but this did not occur until 5/5/11. Additionally, a MBSS was provided on 5/5/11 which indicated silent aspiration and the need to transition to nectar liquids. This resulted in the individual receiving unsafe liquids for 13 days. • Individual #19 was diagnosed with aspiration pneumonia on 7/25/11 but there was no evidence of reassessment upon return or discussion of the event by the PST. There was also no discussion by the PNMT at the 8/3/11 meeting.	
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 being at risk (requiring PNM supports) were provided with a Physical and Nutritional Management Plan (PNMP); however, the plans were not comprehensive as information regarding oral care and medication administration was lacking the detail needed to ensure safe consistent delivery of service. This included lack of staff positioning, and information regarding texture or consistency of liquids or medications. Based on a review of an identified sample of 12 individual records (Sample #1, #2, and #3), individuals were not provided with a comprehensive PNMP as evidenced by: • In two of 12 records reviewed (16%) comprehensive strategies for medication administration were included. • In zero of 12 records reviewed (0%) positioning of staff during medication administration and oral care was included. • In two of 12 records reviewed (15%) comprehensive strategies for oral hygiene were included. • In zero of 12 records reviewed (0%) personal care instructions were included. • In zero of 12 records reviewed (0%) strategies focused on mealtime were specific and detailed. Examples of individuals who were not provided with a comprehensive PNMP included: • Individual #54's oral care section of the PNMP simply stated the position for oral care but not other information relevant to safe oral care. (i.e., how water should be provided and staff positioning). • Individual #51's oral care section did not contain information regarding the need to reduce water or thicken liquids during oral care. The individual was on Honey thick liquids. • Individuals #1, #54, #94, and #21's PNMPs contained vague directions such as "cue to take small bites" or "cue to take liquids: but did not provide information	Noncompliance

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		on type of cues to provide or a descriptor of what constituted a "small" bite for that specific individual. Dining plans were developed by RGSC. These dining plans focused solely on mealtime and included the strategies listed on the PNMP that are relevant to meal intake. Issues noted with the dining plans included: lack of consistency with the diet cards that are provided by dietary, lack of implementation (as stated above), and no revision date or development date on the plan. A positive was that pictures on the plan included adaptive equipment and positioning of the individual during mealtime. Per review of 11 individuals' diet cards and dining plans (sample #1 and #2), two of 11(18%) contained consistent information. Additionally, the information on the dining plans was vaguer than what was listed on the PNMP or Diet Card. For example: • Individual #21's diet card stated to provide small bites and sips but the dining plan stated to monitor pace/amount. • Individual #94's diet card stated to use the "sip by sip" method but this information was missing from the dining plan. If RGSC is going to utilize these plans, they must be consistent as both the card and plan are present at tableside. Additionally, these plans, as mentioned previously with discussion of the PNMPs, must contain specific strategies to help ensure consistent implementation. Per report by Habilitation Services, one of the reasons for the inconsistency was that the Facility was trying to move away from specific instructions such as "alternate bites and sips" but these recommendations many times were determined by MBSS. Prior to moving away from these recommendations, an assessment must be conducted to determine the safety of such a modification. Based on a review of an identified sample of 12 individual records (Samples #1, #2, and #3) PNMPs and dining plans were not formally developed with input from the PST. 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 record review, there was evidence in the PSPs that the PNMPs were included, but there was no evidence of discussion or input from other team members. PNMPS were not reviewed by the PST and were not consistently updated in a timely manner by Habilitation Therapies as indicated by a change in the person's status. In three of eight records reviewed (37%) (Sample #4), PNMPs were revised in a timely manner as indicated by a change in the individual's status. Examples of PNMPs not revised in a timely manner included:	

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		• Individual #113 had a diet downgrade on 5/3/2011 but the PNMP was not revised until 6/6/11. • Individual #62 had a diet downgrade on 6/6/2011 but the PNMP was not revised until 7/20/2011. Failure to update PNMPs in a timely manner result in an increased risk to the individual as staff will not be appropriately updated regarding the needed interventions.	
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.	PNMPs and Dining Plans were generally developed by the therapy clinicians with limited input by other PST members as described above. Generally, the PNMP was located in the Individual Notebook with the person; however upon returning home, the notebooks were locked in the computer room, therefore were not readily to staff. There was also a copy in the dining room in a PNMP binder. At no time during any of the observations was staff observed referring to the PNMPs. In most cases, pictures were available with the PNMPs but these were hard to see and only include a face picture. Pictures related to wheelchair and bed positioning, and the use of orthotics or braces were not included as part of the PNMP or as part of any supplemental plan of care related to PNMP. 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 three of 11 (27%) individual observations (sample #1 and #2), staff was following mealtime plans accurately. Examples of accurate implementation: • In four of four (100%) observations staff was following transfer instructions. • In one of two (50%) observations, nursing staff were following mealtime instructions for medication administration. Individual #54 was not going to be provided with crushed meds as stated per the PNMP until nursing was cued by a member of the Monitoring Team. Failure to provide crushed meds for this individual would have placed him at an increased risk of choking. Examples in which staff did not implement interventions and recommendations outlined in the PNMP and/or dining plan include: • Individual #54 was not monitored for oral pocketing • Individual #80 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. • Individual #94 was not provided cues to eat slowly, take small bites or alternate liquids and solids. • Individual #1 was not cued to take small bites	Noncompliance

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		General observations of the dining rooms also indicated lack of PNMP implementation. For example: • Individual #36 was poorly positioned as chair was too far away from the table. Individual was also observed taking large sips and bites with no cues to correct by staff. • Individuals #150 and #74 were observed eating rapidly with no cues from staff to decrease rate. • Individual #13 was observed eating rapidly when the plan called for cues to slow down and for the individual to put down their spoon between bites. • Individual #108 was not provided with cues to swallow two times per bite as stated in her dining plan thus increasing the potential for increase pharyngeal and oral residue. Overall, there was no improvement in staff knowledge regarding specific plans or the implementation of these plans since the previous visit. Staff did not understand rationale of recommendations and interventions as evidenced by not verbalizing reasons for strategies outlined in the PNMP. Lack of understanding regarding why an intervention was important contributes to a lack of urgency regarding implementation. Based on interviews with four direct support professionals (two on La Paloma and two on El Paisano): • In three of four (75%) interviews with staff, they were able to identify the location of PNMP and mealtime plan. • In zero of four (0%) interviews with staff, they could describe individual-specific PNMP strategies. • In one of four (25%) interviews with staff, they could describe the schedule for implementation of PNMP strategies. • In zero of four (0%) interviews with staff, they 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	Staff were provided initially and annually with general competency-based foundational training related to aspects of PNM by the relevant clinical staff. Review of the Facility's training curricula revealed PNM training in the following areas: • Dining plan • Adaptive feeding equipment • Adaptive equipment (gait belt, lift vest, orthotics, bathing, and range of motion) • Dysphagia	Noncompliance

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	competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	Missing from the training was: • Optimal alignment and support in seating systems and alternate positions • Body mechanics The only evidence of skills based or competency based training was regarding the PNMP and dysphagia and that was in the form of a general ten item questionnaire. There was no evidence of return demonstration or testing that focused on other areas related to PNM or individual specific competency training. There was also not a clear process that ensured pulled staff was provided with individualized training prior to working with individuals who were identified as being at an increased risk of aspiration. Per review of training records (April to July 2011) that occurred in response to downgrades in diet, the Monitoring Team was unable to determine if staff had been trained in a timely manner due to the training sheets lacking dates next to the staff signatures. While there was a date at the top of the training log, there was no date next to the staff's signature. Additionally, two individuals who had a downgrade on 5/3/2011 and 5/4/2011 did not have their staff trained on the texture change until 5/12/2011 and 5/19/2011. Another example was Individual #134 who choked on 7/25/11 but staff did not receive training on the swallowing precautions until 8/9/2011, and then the training was only provided to two staff.	
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.	The monitoring process provided to the Monitoring Team consisted of how to complete the monitoring form but did not indicate frequency of monitors or list the individuals responsible for completing the monitors and the areas of monitoring in which they were responsible. The PNM policy stated that monitoring will be performed as scheduled but there was no schedule provided. Based on review of the Facility's monitoring practices, a comprehensive PNM monitoring form was in place that was designed to address mealtime as well as areas outside of mealtime. While the forms were designed to address mealtime and other PNM areas and had multiple professionals involved, a policy or process was not fully developed that included: • Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk,	Noncompliance

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		• Identification of monitors and their roles and responsibilities, • Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, and • Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician. Per review of the PNMT minutes (3/1/11 to 8/3/11), monitoring was discussed at times during the minutes but analysis of findings as well as the trending of data remained absent. Per monitoring list provided by RGSC, 20 monitors were completed for 11 individuals utilizing the comprehensive monitoring form during the months of April, May, June, and July 2011. A review of Facility monitoring list from 4/2011 to 7/2011 documented that staff were not being monitored in all aspects in which the individual was determined to be at increased risk. Per review: • 18 of 20 (90%) monitoring forms focused on oral intake (meals and snacks) • 1 of 20 (5%) monitoring forms focused on bathing • 0 of 20 (0%) monitoring forms focused on medication administration • 1 of 20 (5%) monitoring forms focused on Oral Care. Also noted was that when an issue was noted (i.e., poor posture or eating too fast), while it was marked on the monitoring form, there was no evidence that staff was provided with on the spot training. Additionally, the frequency of monitoring (20 over 4 months) by PNM professionals was not sufficient to ensure consistent implementation of PNM strategies. See Provision O.3 for examples. An Aspiration Trigger Sheet was developed by central office but there was no evidence that the form was implemented for any of the individuals who were at an increased PNM risk. Implementation of this trigger sheet would assist with the team having a better picture of whether implemented plans are effective in mitigating the PNM risk.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two	Based on the review of 12 individual records (sample #1, #2, and #3), the PNM Team or PST did not document progress of individual strategies on a monthly basis to ensure the efficacy of identified strategies to minimize and/or reduce PNM risk indicators for those	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	individuals with the most complex physical and nutritional support needs. While PNMPs are reviewed at the PSP, there was not a system fully in place that clearly monitored the effectiveness of the plan by tracking clinical indicators for all individuals who are determined to be at an increased risk such as the occurrence or absence of triggers (signs and symptoms associated with physical and nutritional decline that require staff response). Individuals with PNMPs were reviewed on an annual basis but there was no evidence that plans were reviewed by the PNMT or PST as indicated by a change in status. For more information please see Provision O.2 Routine, proactive review of the plans was not conducted by the clinicians with frequency based on health risk level. All members of the PNM team did not conduct monitoring. There was no system established of routine review to be conducted by the clinicians relative to the health status of those individuals at high risk who were followed by the PNMT. There was no formal and consistent review of the PNMPs relative to how well the plan addressed or minimized these concerns. Even during the annual assessments, the plans were reviewed in a more rote manner to continue a strategy with no clear review to measure or evaluate the actual efficacy of the plan. For example, there was no review to determine if strategies to address falls for an individual effectively resulted in a reduction from the previous period. There was no detailed comparative analysis of data or assessment findings.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	The following section was based on two (100%) individuals who received enteral nutrition (Sample 3). One aspect of the At Risk Individuals policy, implemented as of 1/1/11, was an outline for an Aspiration Pneumonia/Enteral Nutrition Evaluation. This form was to be used for all individuals who were at high risk for aspiration pneumonia or who were hospitalized for aspiration pneumonia multiple times within the last year, as well as a means to conduct an annual assessment of individuals who received enteral nutrition. The assessment was to be compiled by the nurse case manager based on information provided by the PCP, nursing, Habilitation therapists, dietitian, pharmacist, and other members of the PST There were two individuals listed as receiving enteral nutrition. Enteral evaluations for	Noncompliance

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		for all enterally fed individuals were requested by the Monitoring Team. All individuals who received non-oral intake (NPO) in the sample had been provided a PNMP that included the same elements described above. Based on the sample of two individuals (sample #3), no individuals had received the interdisciplinary enteral nutrition assessment provided by the State. The two individuals had received a Habilitation Therapy assessment but content lacked analysis regarding potential pathways to intake. While two of two (100%) assessments included why the tube was medically necessary, none of the assessments for those individuals who were NPO identified a clear pathway to oral intake. In other words, just because an individual aspirates during a MBSS does not mean that there are not other strategies to implement to work towards the end goal of resumed oral status. Based upon review, individual trials of intake or a MBSS were the only method attempted by RGSC to increase oral intake. While transitioning from NPO status to Oral status is possible and appropriate for some individuals, there are many steps in between that are available to focus on. Included in this is oral motor strengthening or skills acquisition training related to mealtime intake. All individuals were provided a PNMP and Dining Plan; these elements would likely also be provided to an individual who transitioned back to oral intake. An issue noted through document review was that potential pathways to oral intake were not consistently provided to individuals receiving enteral feeding. For example: • Individual #126's MBSS stated that he aspirated on all consistencies but did not identify any methods to maintain or improve oral musculature in an effort to increase the potential for future oral intake. The need for continued enteral nutrition was integrated into the PSP. Based on a review of two individuals' PSPs, two of two individuals who received enteral nutrition, the individual's PSP clearly documented the rationale for the continued need for enteral nutrition.	

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. (Provision O.8)
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. (Provision O.2)

3. The Facility's PNM NEO training curriculum should be revised to include generic and individual-specific mealtime risk triggers that alert staff to problems, and what staff are to do if these triggers are observed. (Provision O.7)
4. Aspiration Pneumonia/Enteral Nutrition Evaluations should evaluate the potential for moving an individual to a less restrictive form of receiving enteral nutrition. (Provision O.8)
5. 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. (Provision O.6)
6. 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, definition of staff retraining thresholds, a validation/inter-rater reliability process, the use of monitoring reports to assist in the identification of problematic issues and/or trends, the formulation of corrective strategies to address areas of deficiency, and integration of the monitoring system into facility Risk Management and Quality Assurance systems. (Provision O.6)
7. 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. (Provision O.7)
8. Oral care and Medication Administration plans should not only include positioning 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. (Provision O.3)

The following recommendations 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 individual's PNMP.
2. The Habilitation Services Department would benefit from having a commercial level color printer to allow for mass production of PNMPs.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement (POI), dated 8-9-2011 2. Record Reviews: a. Sample 1: Individuals #19,#47, #54,and #134 b. Sample #5: Individuals #15, #19, #35, #51, #62, #77, #79, #80, #93, #118, #140, and #143 c. Sample #6: Individuals #40, #115, and #134 d. Sample #7: Individuals #15, #35, and #93 3. RGSC OT/PT Standard Operating Procedures MR700 06 (January 2010) 4. Current Lists of people: a. Who use wheelchair as primary mobility; b. With transport wheelchairs; c. With other ambulation assistive devices, including the name of the device; d. With orthotics and/or braces; e. Who have had a decubitus/pressure ulcer during the past year, including name of individual, date of onset, stage, location, and date of resolution. f. Who have experienced a falling incident during the past three (4) months, including name of individual, date, location, whether there was injury, and, if so, type of injury. 5. OT/PT assessments template 6. For the past 6 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 7. List of individuals receiving direct OT and/or PT services and focus of intervention **People Interviewed:** 1. Jane Augustine PT 2. Elda Hernandez OTR 3. Betty Perez Rehab Tech II **4.** Five direct care staff (3 La Paloma and 2 El Paisano) **Meeting Attended/Observations:** 1. PNMT meeting 8-22-11 2. At risk Meetings Individual #80 8-22-11 and Individual #40 8-24-10 3. La Paloma lunch and dinner 4. El Paisano lunch and dinner 5. Las Paloma and El Paisano transition times
	Facility Self-Assessment: RGSC's self-assessment identified compliance with Provisions P.1 and P.2 and noncompliance with Provisions P.3 and P.4. The self-assessment was inconsistent with the Monitoring Team's assessment of noncompliance for provisions P.1 and P.2 and consistent with the Monitoring Team's assessment of noncompliance with P.3 and P.4.. RGSC found Provision P.1 to be in compliance based on the fact that all individuals received assessments within 30 days of admission; however, the Monitoring Team found

	Provision P.1 not in compliance secondary to lack of assessment post a significant change in status. Although RGSC reported the Facility complied with the requirement in Provision P.2 because all plans are discussed at the PSP and shift supervisors were completing monitors of the plans, the Monitoring Team found Provision P.2 not to be in compliance due to lack of integration into the PSP and because individuals were not being consistently provided with interventions to enhance current abilities and skills. While assessments exist for all individuals, they were not comprehensive, as the assessment lacked analysis of findings that were based on the data, comparative analysis to previous assessments, and methods to identify and develop the acquisition of skills. This resulted in failure to meet compliance with P.2 Actions Steps were included under one provision but did not include other provisions. Steps taken that were determined to be related to each provision item were included, but there was no clearly stated sequential plan to achieve compliance with each provision. . Much work has been noted yet the current POI format appeared to merely document completion of tasks rather than serve as a well outlined plan to direct focus, work products, and effort by staff. Action steps should be stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps.
	Summary of Monitor's Assessment: **Provision P.1:** This provision was determined to be not in compliance. RGSC had one PT and a part time contract OT. 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 and were not comprehensive. **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. Other than the limited evidence of direct intervention, the primary support provided was via the PNMPs. Intervention plans related to positioning, oral care, and medication administration were not based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies. Additionally, therapy services were not consistently integrated into the PSP. **Provision P.3:** This provision was determined to be not in compliance. Plans were not implemented as written and staff were not knowledgeable of the OT/PT plans. **Provision P.4:** This provision was determined to be not in compliance. A system was not in place to monitor staff implementation of PNMPs and other OT/PT interventions which included: • Definition of monitoring process • Identifies monitors (licensed professional for OT/PT intervention plans) and their roles and responsibilities • Formal schedule for monitoring to occur • Monitors are re-validated on an annual basis by therapists and/or assistants • Results of monitoring activities in which deficiencies are noted are formally shared for appropriate

	follow-up by the relevant supervisor Positives noted during the visit consisted of the Habilitation Department working to open a sensory room, calming room as well as a gym. The gym will assist in the development of more proactive programs to maintain and improve upper and lower extremity functioning. Included in the gym was a seated exercise bike with hand bike, parallel bars, upper extremity pulley, and electric mat for alternate positioning. The sensory rooms should provide an opportunity for relaxation as well as sensory stimulation for individuals at day programming.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	The Facility did not provide an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience. There was one Occupational Therapist who was present for 16 hours per week. There was one Physical Therapist whose responsibilities included being the director of Habilitation Services and PNMT lead, as well as carrying a regular caseload. There was one Rehab Tech II. Betty Perez (Rehab tech II) served as a member of the Habilitation Therapy staff. At the time of the review, many of her job responsibilities were not associated with PNM thus resulting in difficulty completing all the jobs that were required (i.e., adaptive equipment monitoring). Some of the jobs that should be reviewed include the ordering of hospital beds, bed sensors and the tracking of adaptive cups in the kitchen. With the current staffing, ratios for Occupational Therapy and Physical Therapy were 1:73. The staffing ratios were not adequate to address standard OT/PT practices in addition to the increased demand of physical and nutritional supports. Clinicians were responsible for the annual assessments or updates, providing supports and services as needed, reviewing and updating the PNMP, and responding to any additional needs as they came up for each individual on their caseload, with additional supports available from the Rehab Tech II. The OT and PT completed annual assessments/updates collaboratively. Some of those who did not have established PNM needs would likely require occasional supports to address acute injuries or to address more chronic conditions associated with aging. Many others would likely benefit from skill acquisition/enhancement programs related to movement and mobility, as well as fine motor skills and independence. This level of supports and services could not be adequately met with the current staffing levels for PT. Current utilization of the OT did not appear to be appropriate to adequately address individual	Noncompliance

#	Provision	Assessment of Status	Compliance
		needs beyond those related to the PNMP. Based on this review, a very limited number of individuals were provided with OT or PT services beyond the PNMP (only five individuals were receiving direct PT therapy and zero individuals were receiving direct OT services). Sample #6 consisted of 100% of the individuals who were newly admitted since the previous compliance visit. All individuals had received an OT/PT assessment. If newly admitted, this occurred within 30 days of admission (Sample #6). The assessments submitted were completed by both OT and PT. The twelve individuals for sample #5 were chosen by selecting 100% of the high fall risk individuals (three), a medium fall risk individual (one), three individuals receiving direct OT/PT (the first, third, and fifth individual on the list), three individuals who had adaptive equipment (every other name on the list), and three individuals who had experienced the highest number of falls over the previous 3 months. One individual was counted twice due to being selected in the samples as being at an increased risk of falls as well as having a high number of falls. Assessments indicated whether or not the individual required OT/PT supports and services for 12 of 12 (100%) (Sample #5) records reviewed. The OT/PT assessment addressed movement, mobility, range of motion and independence but, as stated in Section O, the OT/PT assessment lacked evidence of assessment regarding medication administration positioning and oral care. There remained a lack of objective measurable data as well as explanation of how these deficits are functionally affecting the individual. Additional concerns noted in the assessment reports reviewed included: • There was no discussion of potential for skill acquisition in areas such as eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. • In many cases, clinical information was merely reported, but was not utilized to guide decisions regarding intervention. • In the cases that therapy supports had been provided, there was no assessment as to the effectiveness of the interventions. • There was no comparative analysis of health and functional status from the previous year. • There was no analysis of findings that was based on the data reported and	

#	Provision	Assessment of Status	Compliance
		compared to a previous comprehensive assessment or update, or that provided a rationale for the recommendations for interventions and supports. • Specific health risk ratings established by the PST were not identified, and interventions, primarily the PNMP, were not specifically linked to these ratings. • The reports lacked review of cognitive functioning. • The reports lacked detail regarding impact on ADLs. Medical issues and health risk indicators were not consistently included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions. Twelve of the 12 (100%) assessments (Sample #5) reviewed contained medical issues and health risk indicators but did not provide information regarding how the risk or medical condition contributed to the overall plan of care. Examples of assessments that did not appropriate rationale included: • Individuals' #80 and #143's OT/PT assessment contained a diagnosis list but did not provide information or links to how these diagnoses impacted the level of care. Evidence of communication and or collaboration was present in the OT/PT assessments. Based on review of 12 OT/PT assessments, 100% included signatures and date of both OT and PT. Individuals for sample #7 were chosen from Falls list provided by RGSC that dated back 6 months. Three individuals with the highest number of falls within the past 4 months were selected. Individuals from sample #7, along with individuals from sample #1, constituted the individuals with change in status. Review of individuals with changes in status did not provide evidence of assessment or review as indicated by a change in the individual's status or as dictated by monitoring results. • Individual #54 was diagnosed with aspiration pneumonia on 4/21/11 but there was no evidence of reassessment upon return from the hospital or discussion of the event by the PST. There was discussion by the PNMT but this did not occur until 5/5/11. Additionally, a MBSS was provided on 5/5/11 that indicated silent aspiration and the need to transition to nectar liquids. This resulted in the individual receiving unsafe liquids for 13 days. • Individual #19 was diagnosed with aspiration pneumonia on 7/25/11 but there was no evidence of reassessment upon return from the hospital or discussion of the event by the PST. There was also no discussion by the PNMT at the 8/3/11 meeting. • Individuals #15 and #93 experienced multiple falls over the period ranging from April to July 2011 but there was no evidence of assessment or review by	

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		the PT, PNMT or PST. Per the Fall Risk and Prevention Policy (3/2007), a PSP addendum should be developed in response to a fall. Part of this process includes PST review of the incident and PT assessment. Based on review of sample #7, this occurred zero of three opportunities (0%). Per report, OTs/PTs were not consistently notified of referrals in a timely manner to ensure completion within 30 days. Orders were sent via fax but follow up regarding receipt did not exist on a consistent basis.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	Based on review of comprehensive OT/PT assessments or updates, PNMPs and associated instructional plans, Activity Plans, Treatment plans and clinician progress notes for 12 individuals (sample #5) receiving OT/PT services, plans were developed within 30 days of the date of the assessment/update as indicated by the assessment. Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. Please refer to Provisions O.2 and P.1 regarding assessments in response to a change in status. Intervention plans related to positioning, oral care, and medication administration were not based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies. For example: • Individual #140's PNMP stated to have the head of bed (HOB) elevated to 45 degrees but there was no assessment present that justified why the assigned degree of elevation was the most appropriate. The issue regarding HOB elevation was a systemic and pervasive issue. The assessment developed by central office had not been implemented as of this review. Failure to provide adequate assessment regarding HOB elevation places the individual at an increased risk of aspiration secondary to reflux. An example is Individual #140 who has poor postural tone and had a difficult time maintaining the 45 degree elevation which resulted in increased abdominal compression. Based on reviews of PNMPs for 12 individuals (sample #5), equipment was specified for 12 of 12 (100%) plans reviewed. Within 30 days of the annual PSP, or sooner as required for health or safety, a plan was developed as part of the PSP but was not consistently reviewed by the PST. Plans were generally limited to the PNMP that was reviewed at the time of the annual PSP and were updated as needed due to a change in status. The main issue was that	Noncompliance

#	Provision	Assessment of Status	Compliance
		there was no evidence that the majority of plans were reviewed by the PST related to program changes or changes in status. Other than the limited evidence of direct intervention discussed above, the primary support provided was via the PNMPs. PNMPs and Specific Program Objectives (SPOs) addressed areas related to positioning, transfers, handling, and mobility, but interventions were limited when related to promoting independence and skill acquisition; interventions did not focus on skills acquisition or independence. PT intervention was generally designed to address gait and ambulation. OT intervention was nonexistent. The few interventions in place were well documented and had established measurable and functional goals. Justification for continued therapy or discharge was well documented in the progress notes. Programs and interventions for other skill acquisition were not identified as a need and, as such, were not provided. The PNMP addressed use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used but lacked the specificity needed to ensure safe oral care and medication administration. Please refer to Section O for additional information. Interventions and/or strategies were not consistently integrated into the PSP. For example: • Individual #140's OT/PT assessment provides methods in which to improve stability, but these strategies were not mentioned in the PSP and were not integrated into the service objectives. • Individual #143's PSP simply stated to continue PNMP and did not provide information regarding contents of the PNMP.	
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.	A s mentioned in Provision O.5, training curricula revealed training in the following areas: • Dining plan • Adaptive feeding equipment • Adaptive equipment (gait belt, lift vest, orthotics, bathing, and range of motion) Missing from the training was: • Optimal alignment and support in seating systems and alternate positions • Body mechanics • Food and fluid consistency	Noncompliance

#	Provision	Assessment of Status	Compliance
		The only evidence of skills based or competency-based training was regarding the PNMP; that was in the form of a general ten item questionnaire. There was no evidence of return demonstration or testing that focused on other areas related to PNM or individual specific competency training. There was also not a clear process that ensured pulled staff was provided with individualized training prior to working with individuals who were identified as being at an increased risk of aspiration. Based on interviews of direct support staff, staff did not understand the rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the OT/PT plans and /or PNMPs. Lack of understanding regarding why an intervention was important contributes to a lack of urgency regarding implementation. Based on interviews with direct support professionals: • In three of five (60%) interviews with staff, staff were able to identify the location of OT/PT plans. • In two of five (40%) interviews with staff, staff could describe individual-specific OT/PT strategies. • In one of five (30%) interviews with staff, staff could describe the schedule for implementation of OT/PT strategies. • In two of five (40%) interviews with staff, staff stated they had received individual-specific training for OT/PT strategies. Examples of direct care professionals who were not able to describe the rationale for OT/PT interventions and recommendations: • DCP on La Paloma was not able to describe why individuals used modified dining equipment. • DCP on El Paisano was not able to describe rationale for maintaining appropriate elevation.	
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	The Facility had not yet developed a system to monitor and address all the requirements of this provision. Per review of OT/PT monitors, a system did not exist that was designed to routinely evaluate fit, availability, function, and condition of all adaptive equipment/assistive technology. A policy did not exist that clearly defines the details of the monitoring system including frequency, implementation and acquisition of data.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	The current system of PNMP monitoring was conducted by the PNMP tech and therapy clinicians. The PNM tech and rest of the PNM team would volunteer to monitor individuals. Monitoring was generally limited to availability and condition of adaptive equipment rather than function and fit. The therapists at a minimum reviewed function and fit during annual updates but there was not a process in place to monitor throughout the year. A formal system did not exist that ensures staff responsible for positioning and transferring individuals at an increased risk received training on plans prior to working with the individuals. This includes pulled and relief staff (Refer to Provision O.5). Based on review of the State and/or Facility's policy, a system was not in place to monitor staff implementation of PNMPs and other OT/PT interventions which included: • Definition of monitoring process • Identifies monitors (licensed professional for OT/PT intervention plans) and their roles and responsibilities • Formal schedule for monitoring to occur • Re-evaluation of monitors on an annual basis by therapists and/or assistants • Results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor Responses to monitoring findings were not clearly documented from identification to resolution of any issues identified. There was no documentation noted directly on the monitoring form that signified on the spot training..	

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

1. The assessment format contained 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, ADLS, and balance should be addressed consistently and 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. (Provision P.1)
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. (Provision P.1)
3. Programs to address weakness or instability with gait should be expanded as part of the overall plan of care. (Provision P.2)
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. (Provision P.4)
5. Restorative and maintenance programs should be developed by OT/PT to prevent decline in ambulation and overall functioning. (Provision P.2)
6. Additional therapists should be hired to assist habilitation services in developing and implementing restorative programs. (Provision P.1)

7. Policies/procedures should be developed for the OT/PT monitoring system, with identified performance indicators that are defined clearly. This system should include, but not be limited to, a systematic and routine review of the components of PNMPs and related equipment, and OT/PT instructional/intervention programs and equipment; staff utilization of the equipment; fit, function, availability, and use of adaptive equipment; and staff competency with PNMPs, therapy instructional/intervention plans, as well as activity plans. There should be established thresholds for staff re-training; identification, training, and validation process for monitors to achieve accurate scoring; and inter-rater reliability methodologies. (Provisions P.3 and P.4)
8. Current therapy services being provided to individuals should be integrated into PSP skill acquisition programs to provide multiple opportunities for incidental teaching, formally and informally. (Provision P.2)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Plan of Improvement (POI), dated 8/9/11 2. Licensure documentation for contract dentists 3. Copy of Appointment Tracking Sheet 4. Procedure for Dental Appointments, undated, no procedure number 5. Standard Operating Procedure, ICF-MR 400-09; Referring Individuals to On-Call MD After Hours, revised April, 2011 6. On-site review of Personal Support Plans for Individuals #31, #48, # 33, #141, #121, #149, #143, #108, #61, #35, #19, and #5, and #2 7. List of Individual who undergo general anesthesia for dental services. **People Interviewed:** 1. Mario Menchaca - Dental Hygienist 2. Yolanda Gonzalez – CNE 3. Mary Doris Matabalan – NOO 4. Jessica Galindo-Juarez – QE Nurse 5. Russ. Reddell, DDS – State Dental Coordinator **Meeting Attended/Observations:** 1. Observations at the living areas and vocational rehabilitation, of Individuals #74, #94, #140, # 1, and #72
	Facility Self-Assessment: The Monitoring Team reviewed the Facility's Plan of Improvement POI, and discussed dental issues with the consulting dental hygienist, State Coordinator of Dental Services, and Facility leadership responsible for Dental Services at the Facility. The Monitoring Team noted that the POI offered only a list of issues completed, but it did not outline an action plan that will lead to future compliance. The Facility considered itself not in compliance with Provision Q, and the Monitoring concurred with the Facility's self assessment.
	Summary of Monitor's Assessment: The Facility made significant improvement in the area of dental services. Subsequent to the last Monitoring Teams last review, the Facility has contracted with a dental hygienist, who is working to improve oral hygiene. Also, the Facility has implemented a much-improved scheduling system that will enable better tracking of dental services. The following are specific issues identified as areas of concern: Provision Q1: The Monitoring Team concluded that the Facility remained not in compliance with Provision Q.1. The Facility had made significant improvements, especially in the area of contracting with a dental hygienist to help provide high quality oral hygiene to individuals at the living area, and by developing a comprehensive process for scheduling dental appointments and dental procedures. The Facility must, however, improve on missed dental appointments, enhance the ability of direct care staff to provide oral hygiene, and establish a meaningful suction tooth-brushing program.

	Provision Q2: The Monitoring Team determined that the Facility remained not in compliance because the PSP process was ineffective in monitoring dental health care issues, addressing desensitization programs, and addressing the use of pre-treatment sedation, TIVA and general sedation, as required by the Settlement Agreement. The Facility must enhance the PSP process to address these issues, and ensure that comprehensive local procedures are in place that delineated a process for the use of general anesthesia, TIVA, and pre-treatment sedation.

#	Provision	Assessment of Status	Compliance
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 Monitoring Team was pleased to see the excellent progress made by dental service, subsequent to the last review. The most impressive improvement noted was the excellent oral hygiene, based on a visual observation, of individuals observed at the vocational and living areas (Individuals #74, #94, #140, # 1, and #72). Good oral hygiene is fundamental for good dental and periodontal health to occur and be maintained. Without good oral hygiene, dental and periodontal care is futile, in most cases. To improve oral hygiene at the Facility, the Facility contracted with an independent dental hygienist, who provided in-services to direct care staff, trained direct care staff to provide oral hygiene to Individuals, and provided direct oral hygiene care at the living areas. The contract hygienist provided services to the Facility two hours per day, five days per week. The expectation is that direct care staff will provide all oral hygiene support for individuals at the Facility, with training and supervision by the contract hygienist. At the time of this review, the Facility estimated that approximately 10% to 15% of direct care staff provide effective oral hygiene (no data were available). The Facility utilized contract dentists from the community to provide all dental services. Individuals were routinely transported to the community dentist's office. The Monitoring Team reviewed licensure credentials of all dentists on contract with the Facility, and noted that all were current at the time of this review. The Facility had established a scheduling system that enables tracking of all appointments, missed appointments, reason for appointment, procedure, follow-up date, need for sedation, and type of sedation, among other important issues. This system enabled the Monitoring Team to effectively track all individual for their dental and periodontal health care needs. The Monitoring Team requested a list of individuals who refused dental services and those who did not receive dental treatment secondary to behavior issues. The Facility was readily able to provide the information. Seven	Noncompliance

#	Provision	Assessment of Status	Compliance
		individuals had missed their scheduled appointments because of refusals, and nine individuals experienced behavior issues that prevented them from undergoing dental treatment; also, 36 individuals had missed their most recent appointment because of non-behavior issues. Of the 36 non-behavioral appointment failures, 11 were secondary to scheduling issues at the Facility. A total of 52 individuals were unable to be provided dental services, because of behavioral and non-behavioral reasons. A process should be developed to improve appointment rates, such as enabling the use of on-site mobile dentistry, enhancing behavior techniques for dental procedures, and considering safe and efficient methods to enhance dental services under sedation, when appropriate. The Monitoring Team reviewed the Facility's Procedure for Dental Appointment, which was undated and did not have a procedure number. The Monitoring Team also discussed the scheduling process with Yolanda Gonzalez, Mary Doris Matabalan, and Jessica Galindo-Juarez. The Monitoring Team commented on the comprehensive process the Facility had in place that ensured appropriate scheduling, and monitoring of dental health care issues. The Monitoring Team learned that the Facility's Dental Scheduling system was based on Microsoft Excel Spreadsheet, and commented that as the spreadsheet data continues to expand, maintaining the data and conducting searches will become extremely challenging for the Facility. The Monitoring Team reviewed the Facility's process for dental emergencies. No dental emergencies were reported during this review period. The process, as reported by Yolanda Gonzalez, Mary Doris Matabalan, and Jessica Galindo-Juarez, ensured that the primary care physician would initially triage the dental emergency, would provide antibiotics and analgesics if necessary, and when appropriate would triage to the local hospital for emergency services. The individual would then be scheduled for follow-up with their community dentist. The Monitoring Team considers this process standard of care. The Facility should develop a written procedure that delineates this process. The Monitoring Team requested the Facility's local procedure for suction toothbrushing, list of individuals who require suction toothbrushing, and the Facility's schedule for suction toothbrushing. The Facility did not provide this information. The Facility has made significant improvements, especially in the area of contracting with a dental hygienist to help provide high quality oral hygiene, and by developing a comprehensive process for scheduling dental appointments and dental procedures. The Facility must improve on missed appointments, the ability of direct care staff to provide oral hygiene, and the use of suction toothbrushing.	

#	Provision	Assessment of Status	Compliance
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 Monitoring Team reviewed the Personal Support Plans for Individuals #31, #48, # 33, #141, #121, #149, #143, #108, #61, #35, #19, and #5, and #2, specific for dental issues. None of the PSPs reviewed on-site effectively communicated dental issues, as required by the Settlement Agreement. There was effectively no integration of dental services into the Team process noted by the Monitoring Team. The Personal Support Plans did not delineate the individual's current dental health care plan, did not address challenging behavior and other issues preventing dental services from occurring, and did not provide insight into desensitization programs and potential need for sedation. The Facility had identified a total of 33 individuals who required a desensitization program. Review of programs to minimize use of sedation and restraint will be described within the body of Provision J of this report. The Monitoring Team requested the Facility's Policy and Procedure for general anesthesia and pre-treatment sedation for dental treatment. The Monitoring Team was provided a copy of the Standard Operating Procedure; ICR-MR; Dental Services, revised May, 2011. The Facility did not have a local procedure that delineated specifically how individuals are supported when provided pre-treatment sedation and anesthesia. As the Facility had nine individuals who routinely underwent general anesthesia for dental services, it was critical that the Facility maintained robust policies and procedures on all forms of sedation, to help ensure safe and effective supports at the Facility. Without well-documented policies and procedures, the Monitoring Team was unable to fully assess the Facility's ability to support the needs of individuals when undergoing sedation for dental procedures. The Monitoring Team determined that the Facility remained not in compliance because the PSP process was ineffective in monitoring dental health care issues, addressing desensitization programs, and addressing the use of pre-treatment sedation, TIVA and general sedation, as required by the Settlement Agreement. The Facility must enhance the PSP process to address these issues, and ensure that comprehensive local procedures are in place to delineate a comprehensive process for the use of general anesthesia, TIVA, and pre-treatment sedation.	Noncompliance

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

1. Ensure that direct care staff address oral hygiene issues more assertively.
2. Develop a process that ensures more individuals are provided timely dental services.
3. Develop a written procedure that delineates the Facility's emergency dental service process.
4. Develop a comprehensive program to ensure the efficacious use of suction toothbrushing.
5. Develop a comprehensive procedure for individuals undergoing general sedation, pre-treatment sedation, and TIVA for dental services

The following are offered as additional suggestions to the Facility:

1. Consider converting the scheduling software to an alternative system that enables data analysis that would ensure the storage, and data manipulation of the specific data field identified for the scheduling software.
2. Consider establishing mobile dentistry at the Facility.
3. Consider increasing the hours of the contracted dental hygienist

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement (POI), dated 8/9/11 2. Record Reviews: a. Sample #8: Individuals #74, #93, #118, and #149 b. Sample #9: Individuals #12, #19, #23, #26, #51, #67, #79, #82, #86, and #94 3. RGSC Communication Services Standard Operating Procedure MR700 07 (1/2010) 4. A list of people with Alternative and Augmentative Communication (AAC) devices 5. AAC evaluation and Speech Language assessment template 6. Monitoring tools template for ACC and SLP programs 7. List of individuals receiving direct speech services, and focus of intervention 8. Behavior Support Committee (BSC) minutes from 3/31/11 to 6/23/11 **People Interviewed:** 1. Belinda Lopez SLP 2. Jane Augustine PT **Meeting Attended/Observations:** 1. PNMT meeting 8-22-11 2. At risk Meeting Individual #80 8-22-11 and Individual #40 8-24-10 3. La Paloma lunch and dinner 4. El Paisano lunch and dinner 5. Las Paloma and El Paisano transition times
	Facility Self-Assessment: RGSC's self-assessment identified compliance with Provisions R.1, R.2, and R.3 with noncompliance with Provision R.4. Provision R.1 was found to be in compliance by RGSC due to having the one position filled by the SLP. The Monitoring Team found Provision R.1 to be noncompliant secondary to lack of staff needed to participate in all phases of care in which communication is either needed or integrated. Provision R.2 was found to be in compliance by RGSC as they stated that comprehensive AAC and Communication assessments were provided; however, the Monitoring Team was not in agreement as the communication assessments were noted to be vague and lacked the detail needed to expand expressive and receptive language skills. Provision R.3 was noted by RGSC as being in compliance but the Monitoring Team found lack of PSP integration and generalization to specific program objectives. The Monitoring Team concurs with the assessment of noncompliance with Provision R.4 Comments stated actions taken that were supposedly related to each provision item, but there was no clearly stated plan to achieve compliance, with progress tracked by completion of each specific action step. This approach appeared to merely document completion of tasks rather than serve as well-outlined plan to direct focus, work products, and effort by staff. Action steps should be stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps.

	Summary of Monitor's Assessment: **Provision R.1:** This provision was determined to be not in compliance. The current ratio for Speech Pathologist to clients was approximately 1 to 73. Evidence gathered through the review indicated lack of participation in all facets of care (i.e., PSPs and monitoring). **Provision R.2:** This provision was determined to be not in compliance. The Communication Assessment did not consistently address expansion of current abilities and development of new skills. **Provision R.3:** This provision was determined to be not in compliance. AAC devices were not consistently available, utilized, portable and functional in a variety of settings. DCPs interviewed were not knowledgeable of the communication programs. **Provision R.4:** This provision was determined to be not in compliance. There was no monitoring of communication devices or integration of communication programs and strategies into the PSP. A positive observation was that individuals were beginning to be exposed to AAC through the use of individual and shared devices; however, there remained the need to increase exposure to a larger variety of devices.

#	Provision	Assessment of Status	Compliance

R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	The Facility did not provide an adequate number of speech language pathologists or other professionals (i.e., AT specialists) with specialized training or experience. At the time of the onsite monitoring review, SLP staffing consisted of Belinda Lopez SLP.
		
		General tasks in which Speech Pathology is responsible:
		• Attendance at:
		  • pre-admission meetings
		  • 30 day planning conferences for all new admissions
		  • Annual planning conferences
		  • PNMT meetings
		  • PSP meetings
		• Conduct/write Communication Assessments
		• Provide direct treatment services
		• Maintain training data as applicable
		• Develop and implement augmentative and alternative communication devices
		• In-service and monitor use of the devices
		• Maintain contact with personnel regarding school age residents
		• Provide consultation, counseling and referral as needed
		• Provide new employee orientation
		• Modified Barium Swallow Studies (MBSS)
			Noncompliance

#	Provision	Assessment of Status	Compliance
		• Meal Monitoring At the time of the review, no individuals were receiving direct speech services or were being monitored by the SLP. At the time of the review, the Speech Therapist continued to pass the development of programs to individuals who lack the expertise needed to write functional and sequential goals. Through the PST process, objectives should be clearly identified as well as the individual most appropriate to develop and follow said goal. This process will improve the likelihood that all goals and objectives are functional and relevant to the intended outcome. Since the topic is communication, the professional most likely to have the needed expertise in developing and revising communication programs would be the SLP. Sample #8 was selected from individuals who were identified by RGSC as having communication devices. The sample was drawn randomly by selecting every other name on the list. Sample #9 consisted of the last five completed communication assessments and randomly chosen assessments (every 4th name) that occurred between the months of April and July 2011. Three of 14 records (21%) (Sample #8 and #9) reviewed indicated individuals with identified language difficulties were receiving active Speech Treatment or participating in a Speech program. Examples of Individuals with identified Speech or language difficulties not receiving services: • Individual #12 had limited speech capabilities but there was no program to address the identified issues. • Individual #67 had decreased long term memory and problem solving skills but there was no Specific Program Objective (SPO) or Specific Service Objective (SSO) to address these areas. Per interview with SLP, time was focused on the development and completion of assessments, and did not permit the time needed to write goals, monitor goals and ensure staff involvement with implementation of the plans.	
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	The communication assessments for sample #8 and #9 were neither detailed nor comprehensive enough to allow for the identification and potential expansion of communication skills. • In zero of 14 (0%) records reviewed the assessment comprehensively addressed verbal and nonverbal Skills.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• In zero of 14 (0%) records reviewed the assessment comprehensively addressed expansion of current abilities. • In zero of 14 (0%) records reviewed the assessment comprehensively addressed development of new skills. • In 14 of 14 (100%) records reviewed the assessment addressed whether the individual requires direct or indirect Speech Language services. While at times the assessments contained recommended strategies or the use of an actual device, the assessment lacked detail regarding the individual's status and was limited in scope due to lack of available trial AAC devices. For example: • Individual #86's assessment stated that the individual answered questions but provided no more additional information or detail • For all individuals in the sample, the primary exposure to AAC was one or two button switches and picture cards. • Individual #93's assessment stated that he follows simple commands but provided no information regarding what the commands consisted of. • Individual #149's assessment stated that gestures were used but provided no further information regarding the catalog of gestures utilized. For persons receiving behavioral supports or interventions, the Facility did not have a process designed to identify who would benefit from AAC or communication assistance. Per review of BSC minutes from 3/31/11 to 6/23/11, an SLP did not attend the meetings nor was there a clear process in place to ensure information was relayed for communication assessment. An example of this was Individual #80 who required the use of a communication wallet to help prevent unwanted behaviors. All individuals admitted since the last compliance visit received a communication assessment within 30 days of admission. Since the previous review, there were three individuals admitted to RGSC. Records for these individuals were requested (Sample #6), Three of three individuals (100%) received a Speech Language evaluation within 30 days of admission. The admission evaluations were signed and dated by the Speech Language Pathologist. Zero of three (0%) Individuals (#51, #74, and #94) recommended to have communication devices or programs were provided with such devices or programs: for example: • Individual #94 was to have speech develop picture cards but there was no evidence that this occurred. • Individuals # 51 and #74's PST recommended a SPO that focused on communication but there was no evidence that this occurred.	

#	Provision	Assessment of Status	Compliance
		• Individual #79's recommendation was to have the individual utilize the shared communication devices at Voc Rehab and at the home. There was no evidence of the shared devices at the individual's home.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	Programs, goals and objectives related to the acquisition or improvement of speech or language were not written by the SLP. In zero of 14 records reviewed (0%), individuals with needs for language acquisition had goals/objectives/outcomes written and followed by the SLP on a monthly basis if service is direct and quarterly if indirect. Rationales and descriptions of interventions regarding use and benefit from AAC were not clearly integrated into the PSP. Zero of the 14 records reviewed (0%) had a clear rationale and description of communication interventions integrated into the PSP. Examples of PSPs in which communication was not adequately integrated included: o Individual #19 and #67's PSP did not mention communication. o Individual #12's PSP simply stated that no speech treatment was needed. o Individual #82's PSP only mentioned swallowing as part of the Speech section. PSPs at times 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. There was no evidence of detailed strategies or translation of nonverbal skills (i.e., communication dictionary) to assist staff with methods to increase communication. The PSPs offered very limited descriptions of how an individual communicated with others**.** In most cases only recommendations from the communication assessment were identified rather than descriptions of the individual's abilities or potentials. Strategies that staff could use to enhance communication were also very limited. Some examples included: • Zero of the 14 records reviewed (0%) clearly identified how the individual communicates with others and interacts with his surroundings. Examples were provided in Provision R.3. • Communication information was not integrated into the daily schedule. o Zero of the 14 records (0%) reviewed had communication interventions and methods to improve communication integrated into the daily schedule.	Noncompliance

#	Provision	Assessment of Status	Compliance
		General AAC devices were not readily available in all common areas. Zero of two (0%) homes had general AAC devices present in the Common areas. Vocational Rehabilitation had five shared devices that were located near the exit doors. While this is a positive step, there was still a need to have devices integrated into the actual activities that were part of the vocational experience. Although the number of devices had increased since the past compliance visit, the use of the devices throughout the day did not increase. During the observations at Vocational Rehab, there was no utilization of the communication boards by the individuals nor was there encouragement to use said devices although there were multiple opportunities (such as transition times) in which the use would have been beneficial and appropriate. Per report, the SLP had been attempting to mount communication devices in the common areas of the homes since the beginning of July but has not been able to get maintenance to install the devices. Communication strategies/devices were not implemented and used. Four observations demonstrated that staff did not implement interventions and recommendations outlined in the Communication Assessment. Examples of individuals where staff did not implement a communication program as written included: • Individual #118 was not observed using photo album. • Individual #74 was not observed using communication wallet. • Individual #93 was not observed using communication wallet.	
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	RGSC did not have a formal or informal monitoring system 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. There was no process in place to ensure communication programs were reviewed by the SLP on a consistent basis. See Provision R.3 for more information.	Noncompliance

#	Provision	Assessment of Status	Compliance
	shall be reviewed and revised, as needed, but at least annually.		

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. (Provision R.3)
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). (Provision R.2)
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, and methods to improve existing language as well as methods to develop new language. Clear direction and detail should be included in all sections. (Provision R.3)
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. (Provision R.3)
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. (Provision R.1)
6. A monitoring system should be developed that ensures availability of AAC equipment as well as the equipment's use.
7. RGSC should install the planned communication devices. (Provision R.3)
8. RGSC should augment SLP staffing so that it is sufficient to meets all the needs of the individuals. This especially relates to the availability of staff to provide modeling and monitoring of goals and objectives, as well as the ordering of equipment. (Provision R.1)

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Plan of Improvement (POI) 8/09/11 2. RGSC Section S Evidence Book 3. Minutes for the Behavior Management Committee (3/31/2011 – 06/23/2011) 4. Contracts for professionals providing external peer review, and intellectual and adaptive assessment 5. Documents that were reviewed included the annual PSP, PSP updates, Specific 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 included the following individuals: #1, #3, #5, #8, #11, #12, #33, #35, #36, #40, #51, #58, #61, #76, #80, #96, #97, #118, #133, and #140 **People Interviewed:** 1. Megan Gianotti, M.Ed. – Behavioral Services Director 2. David Moron, MD – Medical Director 3. Belinda Allen – Active Treatment Monitor 4. Lorraine Hinrichs – Program Director 5. Cheryl Fielding, Ph.D. – BCBA consultant 6. Janie Villa – QDDP Coordinator 7. All QDDPs 8. Direct Care Professionals: Approximately 15 staff members in residences, classrooms and vocational settings **Meeting Attended/Observations:** 1. Risk Management Meeting – 8/22/2011 and 8/24/2011 2. Polypharmacy Workgroup – 8/24/2011 3. Behavior Management Committee – 8/25/2011 4. Human Rights Committee – 8/25/2011 5. Observations were conducted at La Paloma and El Paisano residences, as well as in classrooms, vocational settings, and outside areas of RGSC
	Facility Self-Assessment: The Facility's Plan of Improvement indicated it was not in compliance with any provisions of this Section. This was consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. The Facility's Self-Assessment information as reported was inadequate to determine the progress made toward compliance for all provisions; most information was repeated from the last two reviews. The information contained for the various provisions did not always relate to the Settlement Agreement

	requirements for the specific provisions. There were no relevant observable or measureable data contained in the self-assessment data that indicated how those activities were moving the Facility toward compliance within the respective provisions. There was no clear sequential framework or timelines established to identify how they expected to reach and maintain compliance. The Facility's POI contained a summary of action plans on which they were working to achieve compliance. The action plans were not specific and failed to consistently relate to the requirements of the provisions in the Settlement Agreement. There was no identification of data that would be used to demonstrate compliance. The Facility needs to ensure that the activities and action steps included in the POI address the requirements set forth in the Settlement Agreement for that specific provision. Through a review of the Presentation Book for Section S, record reviews, interviews, and observations, the Monitoring Team was able to validate that some of the activities listed in the Facility's Self-Assessment were carried out and showed improvement in moving the Facility toward compliance for some of the provisions. These activities and improvements are discussed in the Monitor's Assessment and throughout the report.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at. Record reviews continued off-site for several days following the site visit. Based upon the information gathered, it was determined that no provisions in Section S of the SA were in substantial compliance. The most noteworthy finding of the current site visit was the pervasive lack of progress in this section. In many aspects, the conditions observed at RGSC were essentially unchanged from those observed during the first site visit to the Facility. In addition to the overall lack of progress, a selection of conditions from the site visit was particularly noteworthy. First was the lack of active treatment. Slightly less than one third of individuals observed were engaged in a meaningful activity. Considering that this percentage included meals when engagement is often higher and that the observations did not require involvement in a formal training activity to be considered as engaged, this percentage reflected a very low degree of active treatment. A second issue of concern was the lack of formal tracking systems for participation in training activities. For example, the Facility reported that no data existed to support annual habilitation assessments. Furthermore, records relating to community activities consisted of handwritten tallies and unorganized Transportation Checklists. Substantial compliance with the SA will require documentation that is more comprehensive and detailed. Based upon the observations, interviews, and record reviews conducted at the time of the site visit, it was evident that the Facility would need to make a concerted and diligent effort to comply with the SA in the expected timeframes.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>S1</td><td>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.</td><td>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 Facility reported in documentation and interviews that minimal changes had been implemented in the assessment of skills or the development of skill acquisition programs. The assessment and training records for 13 individuals were reviewed to establish the accuracy of the statements about assessment and skill acquisition programs made by the Facility. This review revealed that 13 of 13 individuals lacked assessments that could be shown to be accurate or that had identified real and meaningful needs.
<table>
<tr><th colspan="2">Provision</th><th>3/2010</th><th>8/2011</th><th>Change</th></tr>
<tr><td colspan="2">Skill acquisition plans have been implemented to address needs identified in:</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>a.</td><td>Psychological assessment (K5)</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>b.</td><td>Psychiatric assessment</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>c.</td><td>Language and communication assessment</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>d.</td><td>PSP</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>e.</td><td>Other habilitative, adaptive skill, or similar assessments</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>
In addition to valid assessment procedures, the successful introduction and strengthening of skills requires that the training program includes specific components. Thirteen records were reviewed to assess the status of the skill acquisition programs. Based upon the lack of progress reported by the Facility and substantiated by record reviews and interviews, the current skill acquisitions programs at RGSC were indicated to lack the components necessary for successful skill acquisition. The findings of that review are presented below.
<table>
<tr><th colspan="2">Provision</th><th>3/2010</th><th>8/2011</th><th>Change</th></tr>
<tr><td colspan="2">Skill acquisition plans include components necessary for learning and skill development. At a minimum, these components include the following.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>a.</td><td>Plan reflects development based upon a task analysis.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>b.</td><td>Behavioral objective(s).</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>c.</td><td>Operational definitions of target behavior.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>d.</td><td>Description of teaching conditions.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>e.</td><td>Schedule of implementation comprised of sufficient trials for learning to occur.</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>f.</td><td>Relevant discriminative stimuli.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>g.</td><td>Specific instructions.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>h.</td><td>Opportunity for the target behavior to occur.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>i.</td><td>Specific consequences for correct response.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>j.</td><td>Specific consequences for incorrect response.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>k.</td><td>Plan for maintenance and generalization that includes assessment and measurement methodology.</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>
An example in which skill acquisition could be a focus of PSP planning that was not considered by the Facility was physical and nutritional management. PNMPs and Specific Program Objectives (SPOs) addressed areas related to positioning, transfers, handling, and mobility, but interventions were limited when related to promoting independence and skill acquisition; interventions did not focus on skills acquisition or independence.
Based upon observations, record reviews and staff interviews, it was evident that RGSC had not complied with the SA requirement to provide adequate habilitation services.
</td><td></td></tr>
<tr><td>S2</td><td>Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.</td><td>
The Facility indicated that at the time of the site visit there were no data to support annual habilitation assessments for 100% of individuals living at the Facility. A review of records reflected that an assessment process did take place on an annual basis. This assessment process conducted as part of the PSP lacked the rigor and sophistication necessary to be considered valid.
The only area of progress involved the assessment of intellectual and adaptive ability by the Psychology Department. These efforts were preliminary and inconsistent, however, and only a small number of individuals had been assessed.
<table>
<tr><th colspan="2">Provision</th><th>3/2010</th><th>8/2011</th><th>Change</th></tr>
<tr><td colspan="2">With regard to living, working and leisure activities, records demonstrate annual assessment of each individual in a minimum of the following areas:</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>a.</td><td>Preferences</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>b.</td><td>Strengths</td><td>0%</td><td>33%</td><td>33%</td></tr>
<tr><td>c.</td><td>Skills</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>d.</td><td>Needs</td><td>0%</td><td>33%</td><td>33%</td></tr>
</table>
Attempts by the Facility to assess individual strengths, limitations, barriers, preferences, etc. typically involved anecdotal statements, narrative reports, and generic rating scales. For example, although a PFA was completed for each individual, the process by which
</td><td>Noncompliance</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>preferences were identified consisted primarily of subjective opinions from staff; no formal preference assessments were completed. A PALS had also been completed for each individual living at RGSC. The PALS is not a standardized instrument and had been identified as an inadequate assessment during the baseline visit. The PALS was also indicated as substantially lacking during in CMS surveys.

While these approaches used by RGSC 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. Record reviews at RGSC did not reveal formal and objective attempts to corroborate informal and subjective assessments.</td><td></td></tr>
<tr><td>S3</td><td>Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:</td><td></td><td></td></tr>
<tr><td></td><td>(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and</td><td>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.
<table>
<tr><th colspan="2">Provision</th><th>3/2010</th><th>8/2011</th><th>Change</th></tr>
<tr><td colspan="2">Implementation of skill acquisition plans is adequate for skill development and learning:</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>a.</td><td>Plan method is implemented as written.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td></td><td>As assessed by staff report.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td></td><td>As assessed by observation.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>b.</td><td>Plan is implemented according to the specified schedule.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>c.</td><td>Reinforcement is used appropriately.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>d.</td><td>Prompting and practice are used appropriately.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>e.</td><td>Plan is practical and functional in the most</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

	integrated setting.			
f.	Data are graphed.	0%	0%	0%
g.	The plan is producing meaningful behavior change.	0%	0%	0%

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.

- The lack of active treatment in most settings at the facility
- A lack of staff knowledge regarding general teaching and specific program components
- The lack of task analyses upon which training programs were to be developed
- The lack of adequate skills assessment
- The lack of administrative and supervisory support for program implementation

	Staff	Clients	Engaged	% Engaged	Ratio
Monday					
501 Dining Room	7	8	5	63%	7:8
501 Dining Room	6	8	5	63%	3:4
502 Living Room	3	6	3	50%	1:2
502 Dining Room	3	6	2	33%	1:2
502 Dining Room	7	10	8	80%	7:10
Wednesday					
501 Dining Room	6	12	1	8%	1:2
501 Dining Room	6	13	2	15%	6:13
502 Dining Room	6	9	3	33%	1:3
502 Dining Room	6	13	2	15%	6:13
502 Living Room	0	4	0	0%	0:4
502 Living Room	3	2	0	0%	3:2
Thursday					
Classroom 8	1	6	0	0%	1:6
Classroom 8	1	6	1	17%	1:6
Classroom 10	2	6	0	0%	1:3
Classroom 11	1	3	2	67%	1:3
Classroom 15	2	3	1	33%	2:3
Classroom 20	2	6	4	67%	1:3
Averages	3.65	7.12	2.29	32%	

#	Provision	Assessment of Status	Compliance
		During observations on the RGSC campus, the following specific examples were noted. • On August 22, Individual #85 was observed to stand in the dining room while screaming and clapping her hands for 10 minutes without staff intervention. After 10 minutes, staff prompted her to sit down by stating, "You must sit down to eat." No place setting or food was available for the individual for an additional 11 minutes. • The PBSP for Individual #40 called for staff providing 1:1 supervision to ensure that abundant, enthusiastic attention was offered as frequently as possible. Observations conducted in the Residence 501 dining room on August 22 reflected that the assigned 1:1 staff member offered Individual #40 no interaction for over 20 minutes despite the individual displaying increasing physical arousal and agitation. It was not until the individual threatened physical violence that the 1:1 staff member offered interaction. • On the afternoon of August 24, circumstances in the Lobby of Residence 502 included one individual sleeping, two individuals pacing back and forth, and one individual with his shirt pulled over his head talking to himself. Two staff were in the Lobby area, but both were writing in large binders and were not attending to the actions of the individuals in the room. • On the afternoon of August 25, activities in Classroom 15 included the television program Jerry Springer playing on the television while one individual ate a snack. It was observed that the vocational program at RGSC involved a substantial amount of functional activity, primarily in the form of formal jobs relating to vocational contracts. This level of active treatment was very positive. It was noted, however, that the majority of the individuals involved in this program were self-motivated and possessed the skills necessary to complete the job tasks. 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 living at the facility were not given the opportunity to develop the skills and abilities necessary for transition to living in the community.	
	(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. It was also difficult to review activities in the community due to the manner in which RGSC documented such activities. The Facility submitted two forms of community activity documentation; hand tallies of who participated in the activities and Transportation	Noncompliance

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		Checklist forms. It was not readily apparent how the two processes corresponded or if there were discrepancies between the two. In addition, the total number of Transportation Checklist forms substantially inhibited any attempt for comparison. For the period since the previous site visit, the Facility submitted a total of 875 completed Transportation Checklist forms. If community activities and training are to be effectively monitored, either by the Facility or the Monitoring Team, RGSC will need to develop and implement a more comprehensive tracking system.	

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

1. Address the lack of formal and informal training with the utmost diligence. 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. Ensure that all necessary assessments are completed within the relevant time frames and using the appropriate tools and instruments.
3. 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.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Plan of Improvement (POI) 8/9/11 2. DADS Policy 004 Personal Support Plan Process 7/30/10 3. DADS Policy 018.1 Most Integrated Setting Practices 3/31/10 4. RGSC SOP 200 01 Most Integrated Setting April 2011 5. RGSC SOP 600 01 Personal Support Plan Process October 2010 6. RGSC SOP 600 05 Admissions, Transfers, Furloughs and Discharges April 2011 7. PSPs for Individuals #1, #5, #22, #47, #61, #133, and #149 8. Personal Focus Assessments (PFA) for Individuals #5, #22, #47, #61, and #133 9. Community Living Options Information Process (CLOIP) documents for Individual #1, #19, #67, #91, #121, and #140 10. List of individuals who had have been referred for community placement by the PST since the last compliance visit 11. List of individuals who had requested community placement since the last compliance visit but had not been referred 12. List of individuals who had not been referred solely due to LAR preference since the last compliance visit 13. List of individuals who had been transferred to community settings since the last compliance visit 14. Documents related to the movement of Individual #58 to a more integrated environment, including: a. Community Living Discharge Plan (CLDP) b. Post-Move Monitoring (PMM) Checklist for visit 7/8/11 (document erroneously dated 1/8/11) 15. Documents related to movement of Individual #122 to an SSLC a. CLDP b. PSPAs of 3/30/11 and 7/27/11 16. CLDP for Individual #39 17. Group Home Tour list from 12/17/10-7/30/1 **People Interviewed:** 1. Alma Ortiz, Admissions/Placement Coordinator (APC) 2. Individual #58 3. Liza Pena, Human Rights Officer (HRO) **Meeting Attended/Observations:** 1. Post-Move Monitoring Visit for Individual #58 2. PSP Planning meeting for Individual #140
	Facility Self-Assessment:

	The Facility reported it did not comply with Provision T.1 but did comply with component T.1.h (Community Placement Report). The Facility reported it complied with Provisions T.2 and T.4, and that Provision T.3 does not apply. The Monitoring Team concurs with the self-assessment for the provisions reported as in substantial compliance but also finds the Facility to be in substantial compliance with Provision T.1.e; for this element, the POI reported only about changes in policy, but the change in procedure to carry out pre-move monitoring was not mentioned. The self-assessment in the POI did not provide a status report or details of the Facility's self-assessment process; instead, it listed actions the Facility had taken since the last visit. Activities included revising policies, identifying obstacles to community living and the supports needed to overcome obstacles, and a series of actions related to one individual who was committed to the Facility. Except for a report that one individual was "transferred to the community," no data were reported. The Facility should consider how it might use its internal quality assurance processes, including the development of additional measures, to assess ongoing process toward completion of actions and actual outcomes. For example, the Facility had greatly increased the number of individuals referred for movement, but this was not reported in the Self-Assessment. The Facility also provided an Action Plan in the POI for Provisions T.1.f and g and T.2. The actions listed, while appropriate, do not provide a plan of sequential steps to achieve compliance; however, the action stated as "Not Started" for Provision T.2 appears to be in place along with other procedures needed for the compliance reported by the Facility and found by the Monitoring Team. For each action, a description of evidence was reported. Identifying the evidence of completion of action steps is an improvement to the Self-Assessment process. However, the evidence listed is vague or relates only to whether an action occurred and not whether it is effective in achieving compliance. For example, action step #1 for T.1.f and g is to "Audit monthly 100% of community discharge plans." Evidence is "Results of monthly audits." There is no indication of what specific data will be reviewed.
	Summary of Monitor's Assessment: The Monitoring Team found the Facility to be in substantial compliance with Provisions T.1.e, T.1.h, T.2, and T.4, and not yet in compliance with other provisions. Although only one person had moved since the last compliance visit, the Facility had made significant progress in increasing the number of individuals referred for movement to a more integrated setting. The Facility still needed to continue expanding its actions to encourage individuals to move to a more integrated setting. It was positive to find that the PSP annual planning meeting observed during the visit began with a focus on whether the individual was interested in moving to a more integrated setting and included thorough and integrated discussion of the supports that would be needed for transition. The format of PSPs reviewed by the Monitoring Team made it difficult to determine what was specified as supports and services needed to move to a more integrated environment versus supports currently being provided or suggested for provision at RGSC. Furthermore, obstacles to movement were listed that could

	and should routinely be made available by other providers in community settings, and strategies to overcome obstacles were not consistently addressed. The Facility had not yet completed assessments of all individuals for placement. Professional members of the PST had not documented determinations of appropriateness of community living nor were recommendations routinely found in assessments. Supports listed in the CLDP were determined by the APC based on review of the assessments and of the PST discussion. The PST should be responsible for identification of the supports. The Facility had established a pre-move site visit process to ensure essential supports are in place at the time of a move. Post-move monitoring visits were thorough and timely. Because the list of supports in the CLDP needed does not flow from the PSP process, the monitoring may not cover all needed supports. Nevertheless, through the APC's knowledge of the individual, review of important supports that were not listed in the CLDP was done. One individual was transferred to an SSLC. CMS-required discharge planning processes were carried out.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the	One person of 71 in residence (1%), Individual #58, had moved from RGSC to a more integrated setting since the last compliance visit. This small amount of movement does not reflect the significant improvement in meeting the requirements of this provision. At the time of the last visit, two individuals had been referred to move to a more integrated setting. The Facility provided a list of nine individuals who, at the time of this visit, had been referred since the last visit and, per interview with the APC (who was responsible for referrals and for post-move monitoring), had increased that to ten individuals by the beginning of the visit. One of the two individuals on the list at the last visit had moved. The other individual (Individual #140) had participated in a 10-day visit to a home but had chosen not to move there; at the PSP meeting held during this visit, the PST continued to plan further exploration of other living options in order to seek a referral to a different home. Actions the Facility had taken to encourage movement to a more integrated setting included providing tours to homes and day activity and vocational sites. The Facility tracked these visits by date, individual, area toured, and staff. A list provided to the Monitoring Team documented that there had been 19 tours between the end of the last	Noncompliance

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	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.	compliance visit and 7/30/11. An unduplicated count of 17 individuals out of 73 people served (71 in residence and two who moved during this time period), or 23%, made at least one visit. This is a very positive step. Furthermore, Facility staff accompanied the individuals, which provided an opportunity for them to learn more about what is available in more integrated settings. The APC reported two other initiatives in process. She was developing a photo album of homes and providers that can be shown to individuals, families/LARs, and staff to provide information on what might be available. She also was working on a questionnaire for staff to take to group home tours so they can make sure to ask about whether the home can provide the supports an individual needs. In addition to Facility actions, a process of informing individuals, families, and LARs about community living is the responsibility of Tropical Texas Behavioral Health, the local Mental Retardation Authority (MRA) through the CLOIP process. The Monitoring Team reviewed CLOIP documents for six individuals. All six documents (100%) reported contact between the MRA staff and the individual, the individual's family/LAR, or both. All described information that was provided to the individual and/or LAR and summarized discussions of preferences. The Facility reported there were eight individuals who are not eligible for Medicaid benefits because they are not legal residents. The family of one additional individual was able to accomplish eligibility after several years of efforts, and the individual will move in the near future. The HRO reported that she is trying to find attorneys to assist with this process. Although this problem is outside the control of the Facility, the State should investigate what steps might be taken to permit provision of services in a more integrated environment, whether or not an individual is eligible for Medicaid services. The Facility provided a list of five individuals who had not been referred for placement solely due to LAR preference. One of those individuals had gone on visits to community homes and day habilitation sites. The Facility reported that no individual who requested community placement had been denied referral; the Monitoring Team could not confirm that but did not find evidence in reviews of PSPs that would indicate this was inaccurate. The Facility did not provide information on how actions to encourage movement are tracked and how effectiveness of these actions is measured. The Facility did track individuals referred by name. Although it was clear that the Facility had taken actions to increase the number of referrals, and (given the small population of the Facility) it was relatively easy to track pace of referrals by reference to a list, the Monitoring Team has two concerns:	

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		• The improvement actions were initiated and organized by the APC. Although the PSTs addressed referral positively during the observed meetings, maintenance of these initiatives still depended on this one staff. The Facility needs to establish additional staff involvement that includes the QMRPs and/or other staff to continue development, planning, and implementation of actions to encourage movement to more integrated settings. • Development of CLDPs and identification of supports were done primarily by the APC. This should be a function of the PST, with assistance and consultation from the APC. The identification of supports required for movement needs to grow out of the routine identification of supports in the PSP, which is developed by the PST. Clear statement of supports in the PSP actually needed for safe and successful life in a more integrated setting might help individuals, families/LARs, and staff to have an accurate picture of the availability of such supports from providers in community settings and to encourage exploration of the availability of such supports.	
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:	Two policies had undergone revision—SOP 200 01 Most Integrated Setting and SOP 600 05 Admissions, Transfers, Furloughs, and Discharges. These policies provide the procedures for referral, transition, and discharge. QMRPs had participated in Q Construction Training as described in Provision F.2.e. This training should assist in improvement of the transition and discharge processes if they result in improvement in identification of supports needed based on individuals' preferences and needs.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs	DADS policies 004 Personal Support Plan Process and 018.1 Most Integrated Setting Practices require the PST to identify in the individual's PSP the protections, services, and supports that need to be provided. The Monitoring Team observed the only annual PSP planning meeting held during the visit. The PSP planning meeting for Individual #140 began with a focus on whether the individual was interested in moving to a community setting. Both Individual #140 and her LAR were interested in such a move. The Living Options discussion was thorough; Individual #140 and her LAR participated, and PST members including direct care staff engaged in integrated discussion of the supports that would be needed and of the components of the environment that would meet the individual's and LAR's preferences, including location. The Monitoring Team reviewed the living preferences and the services and supports identified as needed in the PSPs of Individuals #1, #5, #22, #47, #61, #133, and #149.	Noncompliance

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	and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The format and contents of the PSPs made it difficult to determine what was specified as supports and services needed to move to a more integrated environment versus supports currently being provided or suggested for provision at RGSC. In all the PSPs reviewed, the section on supports and services needed found in the Optimistic Living Vision discussion included supports and services needed in a more integrated environment, reports of health and behavioral status as well as services currently being provided, and recommendations for supports to be provided by the Facility. The PSP contents for this section should be a specific listing of supports that would be needed in the most integrated setting determined by the PST as appropriate. In three PSPs (43%), obstacles to movement were listed that could and should routinely be made available by other providers in community settings. These included: • Individual #5 requires daily supervision. This individual also requires assistance during transitions due to unsteady gait. A list of clinicians (e.g., physician) was provided who would need to follow the individual's care. All of these may be appropriately listed as supports and services needed but should not be obstacles to movement. • The obstacle listed for Individual #61 was behavior and the current implementation of a PBSP. There was no indication that the Facility had investigated and determined that possible service providers and the MRA could not provide behavioral services to meet this individual's needs. • Individual #149 had, as obstacles, need for a BSP and need to be followed by a physician. The Facility had not determined that these were unavailable from providers. PSPs did not consistently address strategies to overcome obstacles to movement. For example: • The PSP for Individual #133 reported that she had visited three group homes in the prior year but had expressed a preference to continue living at RGSC. The PSP reported that the only obstacle to moving to a group home was her resistance to a move. No Action Plans were developed to address this obstacle. The PST determined that the most integrated setting at the current time is that the individual "will continue to benefit from remaining in the facility." • For Individual #47, the MRA reported, regarding services and supports needed, that the individual may require more hours of SLP to return him to oral feeding than may be possible; the team and MRA were not able to state how many hours that would be, but noted in the PSP that people have not been referred because they could not get enough medical service reimbursed; this should have been stated as an obstacle. Appropriately, the PST and MRA included in the PSP a plan for the MRA to determine the units of service that could be funded. This would permit the PST to determine whether this is an obstacle to movement.	

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		The new PSP process was predicated on beginning with a vision for the individual as the basis for identifying the supports and services 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. This vision was intended to be developed through the Personal Focus Assessment ({PFA) completed by the individual, family/LAR, and PST. As no PFA meeting was scheduled during the visit, the Monitoring Team could not observe the process. However, the Monitoring Team reviewed PFA documents for Individuals #5, #22, #47 and #133. The PFA involves an extensive listing of questions about a range of areas rather than a focused discussion that can be guided by the individual or by knowledge of the individual's preferences. At least some PFA documents provided by the Facility for all four individuals (100%) had large gaps in which information was not provided; the Monitoring Team does not necessarily find this inappropriate but does suggest review of the PFA process to make it more useful. For two of these four PFAs (50%), the PFA identified a preferred living environment; in both cases, that environment was RGSC. For two individuals (50%), multiple documents were provided. • For Individual #47, the Monitoring Team was provided with five separate PFA documents. Two were dated 11/15/10, one was dated 1/13/11, and two were dated 1/14/11. Three reported his preferred living if not at RGSC would be a group home; one reported it would be "close to family." There was no evidence of an attempt to reconcile these answers. These was no evidence that these were the results of discussion among the individual or LAR, or even among the members of the PST. • For Individual #133, the Monitoring Team was provided with five separate PFA documents. Two were dated 11/15/10 (one of which had, handwritten, "6-2 shift"), two were dated 2/14/11 (one of which provided responses only to questions relevant to behavioral services and had only the signature of the psychology assistant on the signature sheet), and one was undated but "Voc" and "due 2-11-11" were handwritten. Various answers were written for the item asking where she would like to live if she moved from RGSC; no documentation was provided of any attempt to reconcile the varying responses. All of this indicates that this was not the result of a meeting at which there was a discussion of the individual's preferences and interests. The PSP, as reported above, stated that the individual had visited three group homes and had expressed a preference to remain at RGSC. This was not clearly documented through the PFA process.	
	2. The Facility shall ensure the	RGSC SOP 200 01 requires the Facility to hold an annual community provider fair or	Noncompliance

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	provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	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. The Monitoring Team requested a list of all trainings and educational opportunities provided to 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. In response, the Facility reported that a provider fair had been held in February 2011, and Tropical Texas MRA provided living options through the CLOIP process at each PST annual meeting. Twenty-eight individuals visited group homes between 3/2011 and 7/31/2011. The Facility provided a list of visits and the individuals who participated (please refer to Provision T.1.a for detailed review of the list); the number of visits had increased compared to prior 6-month periods. 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; the individual who had made such a decision prior to the last compliance visit did not tour any additional facilities since then, but the PST identified that as an action to be taken (at the PSP meeting held during this compliance visit). The Monitoring Team reviewed a sample of six CLOIP worksheets. All listed materials provided to the individual or LAR. Two (33%) reported visits to community living options by either the individual or LAR. No other educational efforts or activities were reported. There was no evidence provided that indicated the Facility held regular meetings with the MRA to identify obstacles to movement and seek development of services, or to develop other procedures to encourage individuals and LARs to consider movement to a more integrated setting. In the PSP process itself, there were few examples of attention to assessment of the individual's need for education in this area and few actions included beyond visits to group homes. The PSP process should establish individualized plans. If an individual does not want to participate in group home tours, the PST should identify other	

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		opportunities for learning about community living, including community-based social activities and involvement in vocational and activity programs operated by community providers as a transitional step toward movement to more integrated living. Although the Facility had taken steps to provide education to individuals and their families/LARs about community living opportunities, the Facility and State need to do more so people can make informed choices. The APC was developing other educational processes that may help to establish compliance when implemented.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	The Facility process for assessment was to include that as part of the PSP annual planning meeting. This was to begin with a CLOIP assessment "conducted by the contract MRA in RGSC's service area" at least two weeks before the individual's annual PST meeting. This information is to be used in the discussion of living options. The list of individuals assessed included 44 individuals out of 71 living in the Facility (62%), all with PSP dates between January and July, 2011 (that is, during the period the new PSP process has been in place). Such an assessment must result in an independent determination by the professional members of the PST of the most integrated appropriate setting (recognizing that the individual may object to that, so that the PSP would not include referral for placement). The Monitoring Team reviewed PSPs for Individuals #1, #5, #22, #47, #61, #133, and #149 and determined that the PST did not consistently make professional determinations of the appropriateness of placement in a more integrated setting. For example: • For six of these individuals (86%), the PSP documented that the "most integrated setting at the current time is" RGSC (or that the individual would "Continue to benefit from remaining in the facility."); no determination was listed for the other individual. • Discipline assessments provided by the Facility for six of these seven individuals (the Monitoring Team did not request those assessments for Individual #1) also did not include recommendations regarding the most integrated appropriate setting, with only a couple of exceptions (such as the annual medical assessment for Individual #47). This was true even though the only obstacle to movement listed for Individuals #22 and #133 was the individual's preference to remain at RGSC. • For Individual #133, the PST determined that the most integrated setting at the current time is that the individual "will continue to benefit from remaining in the facility." Given that there were no obstacles other than the individual's preference, it would seem that the professionals on the PST did not make an independent determination. It would be helpful for the Facility to develop a tool or other guidance to assist PSTs in	Noncompliance

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		making decisions about the appropriateness of movement to a more integrated setting. Because not all individuals had yet been assessed, and because of the lack of determination by the professional members of the PST, this provision element is not yet in compliance.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	The APC reported the process for development of a CLDP. When an individual was referred for movement to community living, the APC participated in the PSP or update meeting. She noted information on supports and services needed and began preparation of the CLDP. She then waited for special staffings and added information to the CLDP. During this time, tours to possible provider homes and activity/vocational sites were made, and the names of possible providers were added to the CLDP. The APC had been placing the last assessment from the individual's record into the CLDP; the PST is now required to send updated 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. The Monitoring Team reviewed CLDPs for Individuals #39 and #58. Although both CLDPs contained many of the requirements for compliance, neither fully met the standards for such a plan. One issue was timeliness. One of two CLDPs (50%) was dated 17 days prior to the scheduled move and three weeks following selection of a specific home; to provide adequate time for implementation of all essential supports, the CLDP should be completed as soon as possible. Although DADS Policy 018.1 requires the CLDP to be developed timely when an individual is accepted for movement to a specific setting, the Monitoring Team suggests that the CLDP be completed at time of referral, as is the current DADS-specified procedure, so that the supports and services in the plan can be considered during review of possible settings and so that the CLDP needs only final revision when a setting is determined.	Noncompliance
	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	The CLDP process is a continuation of the Facility's responsibility to assess the needs of an individual who will be moving to a more integrated community setting, and to ensure that the community setting adequately meets those needs. The identification of essential and non-essential supports must begin by considering those things identified in the PSP. The PST did appear to rely heavily on the PSP and the assessments associated with the PSP to guide the identification of the essential and non-essential supports. The potential problem with this was that it was not clear the PSTs were proficient in overall needs assessment, the interdisciplinary process necessary to integrate the assessment findings	Noncompliance

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	provider staff.	into a comprehensive support plan, or finally, the identification of the supports and services needed and desired in a community setting during the PSP, as described in Section T1b, Section F1c and Section F2a. CLDPs listed Essential Supports needed at the time of the move and other supports that could be provided later. The listing of supports was not yet adequate for compliance with this element; not all supports and services identified in assessments were included. Because the Post Move Monitoring (PMM) visits require review of all supports listed, it is critical that any identified support needs are placed on the list; this was not always done. For example: • Individual #58 had a PBSP for significant behavior problems that could endanger success of community living; no behavior support plan, follow up by a behavioral specialist, or training of provider staff about this issue was included in the CLDP. The CLDP did list an inservice training by Psychology but did not include that on the list of supports, nor was there any indication of what was to be trained. • A non-essential support (that is, one that did not have to be provided at the time of the move but would be needed later) was to "Monitor during all meals and snacks for aspiration and choking precautions." This issue was not discussed in any of the assessments included on the CLDP. If it is an issue requiring monitoring, it should be an essential support, as it could result in impaired health or death. It should also lead to an essential support of training for staff at the new setting. Training on diet texture and training for food preparation were both listed, assigned to Facility staff, and given a date, but neither was put on the list of supports. Per interview with the APC, she developed the lists of supports while participating in CLDP and PSP meetings. Developing the list of supports should be the responsibility of the PST in order to ensure continuation from the PSP and a thorough listing of those supports needed for health, safety, and adjustment to the new living setting.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	For one of two (50%) CLDPs, Facility staff responsible for actions were identified. For the other, only "RGSC" was identified. For two of two (100%) CLDPs, timeframes were specified.	Noncompliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-	Documentation was not provided that verified review of the CLDP with the individual, family, or LAR. The CLDP for Individual #58 included information on his visits to settings and his responses to those visits, but not on supports and services to be provided.	Noncompliance

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	making regarding the supports and services to be provided at the new setting.		
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	For one of two (50%) CLDPs, required assessments were completed more than 45 days before the individual moved, and no updates were provided by to the Monitoring Team. Review of the more recent CLDP and discussion with the APC indicates this might have been resolved.	Noncompliance
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 Monitoring Team was provided with a checksheet for a pre-move site visit by the APC for Individual #58. This sheet included a listing of each essential support identified in the CLDP as well as a review of the home and day service environments (including fire evacuation plans and fire extinguishers), transportation, activity schedule, and inservice training. The APC documented presence of each item required. The Monitoring Team notes that not all supports indicated as needed by the assessments for this individual were on the list of supports needed but rates this issue under Provision T.1.c.1. Included on the checksheet was documentation that training on the behavior support plan was provided to staff at the new setting prior to the move, and that training of additional staff would be checked at the seven-day monitoring visit. For Individual #39, whose move was scheduled but had not yet occurred, a date for a pre-move site visit was documented on the CLDP. The process for verifying that the supports listed on the CLDP are in place was well-designed, implemented, and, for the one person who had moved, documented. This provision is therefore found to be in substantial compliance. However, the Facility needs to ensure that all essential supports are identified in the comprehensive assessment in order to ensure the site visit monitors all needed supports.	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 provisions of this Section T.	No evidence was provided to the Monitoring Team of a process to ensure that community living plans are developed, and that the Facility implements plans. The POI reported that the ICF Director will meet with the APC monthly to discuss CLDPs and will review all CLDPs. The Facility should develop a more formalized quality assurance process to include specific requirements and criteria for ensuring plans are adequate, are implemented, and are timely. This should include a process to ensure supports to ensure a safe and successful transition are adequately included in the CLDP.	Noncompliance
T1g	Each Facility shall gather and	At the Facility level, RGSC was not in compliance with this provision. The Facility did not	Noncompliance

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	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.	report a formalized process to gather and analyze information related to identified obstacles to movement to more integrated settings. In response to a request for a facility-wide needs assessment regarding provision of community services and obstacles to such placement, and to a report summarizing obstacles to individuals' movement, the Facility provided a list of individuals referred for community placement and stated the facility-wide needs assessment was not applicable. However, the Facility also provided a list of three primary obstacles for placement and how they are being addressed. To comply with this provision element, the Facility will need to gather and analyze obstacles to movement for all individuals served. The Facility should perform some type of analysis or interpretation of the data (i.e., a comprehensive assessment), such as a narrative in which they can provide more depth to the straight numbers, and provide that to DADS. The analysis should be predicated on a consistent methodology for collecting information that is described at the outset of the report. Examples of possible sources for relevant data that could inform a truly comprehensive assessment include: • Barriers identified by the PST during the assessment for placement and reflected in the annual PSP Living Options Discussion of the PSP • Barriers perceived and/or encountered by individuals, families and LARs, as documented by the PSTs and through Parents and Self-Advocacy groups • Post-Move Monitoring Checklists could be analyzed and common issues identified. DADS had issued its first annual Obstacles Report for the State Supported Living Centers in October 2010, which provided guidance to the Centers as to the methodology and categories of obstacles to be used in order to ensure the State Office receives comparable and consistent data from each one. In terms of methodology, this process relied heavily, as appropriate, on the PSTs to identify the obstacles on an individualized basis for each person. It also referenced the newly revised PSP process that was currently being introduced to the facilities, and stated that specific direction would be given to the PSTs under this new process to address the content of the Living Options discussion to include both the individual's and his/her LARs awareness, experience, and exposure to alternate living arrangements. The revised process was also described as including "a Personal Focus Assessment that will provide the PST with the individual's interest in pursuing alternate community placement, along with a geographic location for possible future placement, prior to the annual planning meeting. This will provide the PSTs with three months to explore the identified geographic location for obstacle identification prior to the Living Options discussion at the annual PST meeting." The PSTs continued to need further training to adequately perform these tasks that form the basis for obstacle identification.	

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T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	RGSC reported in the POI that it was in substantial compliance with this provision element. The Monitoring Team concurs. The Facility provided a Community Placement Report in the format determined by the state. Nevertheless, the Monitoring Team has a concern. Although the Facility was using the correct format and provided information about individuals who had been referred and had moved, RGSC reported in the category of "Individuals Prefers Community—Not Referred—LAR Choice" that no individuals were in that category. However, the Facility had reported that there were five individuals who were not referred because of LAR choice; although this discrepancy might have been due to interpretation that the individuals did not express preference, it is unclear whether the Community Placement Report is accurate or not. Because the Facility professionals did not make determinations of the appropriateness of community placement when a LAR reported not being interested or being opposed, it was not passible to determine whether the made an accurate determination of which individuals would prefer to move but remain only because of LAR choice.	Substantial Compliance
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two	The Facility reported in the POI that it was in substantial compliance with this provision element. The Monitoring Team concurs.	Substantial Compliance

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	years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	Individual #58 moved from the Facility since the last compliance visit. The seven-day PMM was done timely. The 45-day PMM visit was completed during this compliance visit and was observed by the Monitoring Team. The Monitoring Team also reviewed the PMM Checklist for the seven-day visit. At the 45-day PMM visit, the APC observed and interviewed staff at both the individual's residence and work site. She interviewed the individual at the work site. At both sites, she did visual checks to ensure each support identified on the CLDP was in place. For issues that could not be observed (such as 24 hour awake staff), she interviewed staff to determine how that was done. With regard to the content of the checklists, the checklists reviewed generally utilized the revised format, which was consistent with the format attached to the Settlement Agreement as Appendix C. A significant improvement was that the methodology being used to confirm the existence of necessary protections, supports, and services was generally stated. This was facilitated by the addition of an "evidence" column, which identified the evidence that the Post Move Monitor was expected to review during the monitoring process. A "comments" column also facilitated provision of an explanation of what was done to confirm compliance, as well as narratives describing both positive and negative findings. As discussed in the Monitoring Team's previous report, an overall concern was that there was no longer a "Yes/No/N/A" column on the checklist, and it was only by reading the narrative in the comments section that a determination could be made with regard to whether or not the essential and non-essential supports were in place. The APC did complete the visual checks for each item and the interviews needed to verify that each support was in place. The interview of the individual and the staff identified one action that had not been completed—sign-up for vocational services with the department providing vocational rehabilitation services. Staff reported that the individual had gone to an appointment, but no letter from the department had arrived. The APC requested the caseworker to follow up and indicated this would be checked at the 90-day visit. The APC asked about numerous other issues not covered in the list of supports, such as nutrition; Individual #58 was able to report about what he can and is not permitted to eat due to medical conditions (which were important but not listed as supports needed); it was clear the APC had extensive knowledge of the individual and went beyond the list of supports in the CLDP to determine whether the individual's needs were being met. Documentation on the checklist for the seven-day visit covered all supports listed in the CLDP. The Monitoring Team suggested to the APC that she document verification by stating the evidence to be used; for example, if the evidence for transportation were	

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		"visual sight of vehicle," she should document that she saw the vehicle. The primary barrier to thorough and valid PMM visits was the lack of complete specification of needed supports in the CLDP.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	The Monitoring Team accompanied the APC to both sites during the PMM visit held during the compliance visit. The PMM accurately identified the presence of supports in the CLDP and the presence or absence of other issues that might affect the success of the placement.	Substantial Compliance
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.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-	RGSC SOP 600 05 addresses and provides procedures for transfers to other facilities of the state. The requirements of this SOP cover the CMS-required discharge planning procedures.	Substantial Compliance

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	required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	Individual #122 was transferred from RGSC to a State Supported Living Center (SSLC). Per CLDP, reason for the discharge was that the LAR wanted the individual to move. Per PSPAs of 3/30/11 and 7/27/11, the individual participated in discussions of whether to move and of information to be provided to the SSLC. There was no indication in PSPA notes or in the CLDP that the individual objected to the move. The CLDP contained summaries of information from psychological and medical assessments. The Monitoring Team did not review the assessments and did not determine how recently they had been done. The PSPA of 7/27/11 included documentation that the "PST met to discuss pre admission staffing" for the transfer. According to the sign-in sheet, the individual, guardian, and PST including direct care staff participated. The process for transfer of this individual met the requirements of CMS discharge procedures. The purpose was the request of the LAR, the Facility provided adequate time to prepare the individual for the transfer, the individual and guardian were involved in planning, and the CLDP provided a summary of the individual's status adequate for planning by the SSLC that would provide services. Although documentation was not provided to the Monitoring Team of the right to an administrative hearing to contest the transfer, documentation was provided that this transfer was at the request of the LAR, and all other relevant requirements of RGSC SOP 600 05 were followed. Therefore, because the Facility had a policy in place and implemented it, this provision is found to be in substantial compliance.	

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. (Provision T.1.b.3)
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. (Provision T.1.b.3)
3. Development of the CLDP needs to be done by the people who have been planning services through the PSP process, including direct care staff. (Provision T.1.c)
4. The Facility should develop a more formalized CLDP quality assurance process to include specific requirements and criteria for ensuring plans are

adequate, are implemented, and are timely. (Provision T.1.f)

5. 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. (Provisions T.1.a and T.1.b.2)

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Plan of Improvement (POI), dated 8/9/11 2. RGSC SOP MR 200 04 Process for Reviewing the Need for Guardianship February 2010 3. DADS draft policy 019 Guardianship/Advocate undated 4. Texas Administrative Code Title 40, Part 1, Chapter 4, Rights and Protection of Individuals Receiving Mental Retardation Services 5. Texas Probate Code Chapter XIII, Guardianship 6. RGSC Guidelines for Rights Assessments 7. RGSC Determination for Need of Guardian/Priority Tool 8. RGSC Individual Rights Documentation form 9. Course Sign-In Sheet Need for Guardianship 7/27/11 10. List of new guardianships obtained 11. List of individuals titled Absence of Guardian 12. Need for Guardianship Record 07/27/2011 13. Consumer Needs Assessment Form for Individuals #5 14. Contact Log for Guardianship 15. Criteria for prioritization 16. PSPs for Individuals #5, #17, #27, #47, #54, #77, #98, #107, #133, and #149 **People Interviewed:** 1. Liza Pena, Human Rights Officer **Meeting Attended/Observations:** 1. Self-Advocacy Council
	Facility Self-Assessment: The POI listed a number of activities intended to increase availability of guardians and to assist in identifying priorities for guardianship. These were appropriate activities. Nevertheless, the Facility described a sequence of steps leading toward a revised prioritization of need for guardianship but not a plan of action base on a set of sequential steps to lead toward establishment of guardianships.; in part, this was due to the need to wait for a policy from DADS which could then be operationalized for the Facility. The POI did not assess status based on data about guardianship. The POI included actions taken to improve rights acknowledgement and understanding of rights by the Human Rights Committee and individuals served by the Facility. Although these do not specifically related to compliance with requirements of this Section, the Monitoring Team agreed that these were valuable activities related to the topic of consent and to making appropriate decisions about rights and about supports and services to be provided.
	Summary of Monitor's Assessment: RGSC was not in compliance with either provision of this Section.

	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. 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. Although 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. Guardians had been obtained for one newly admitted individual and three individuals whose guardianships had lapsed. Although the HRO was making attempts to find resources for guardianships, there will be a need for a structured and active recruitment program once the statewide policy is implemented.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The Facility updated criteria used to rank individuals on need for guardianship, and the Human Rights Officer trained QMRPs and the QMRP Coordinator, the director of behavioral services, an HRC member, a unit supervisor, and a nurse on the criteria. As part of the training, these staff reviewed each individual and revised the priority listings. Per interview with the Human Rights Officer, many changes were made in the priorities for individuals. Criteria were categorized into five components: • Has been deemed incompetent through the court system and currently does not have a guardian • Has a high risk and/or history of abuse/neglect and/or exploitation • Has serious ongoing medical/psychiatric issues • Use of psychotropic medications • Has severely impaired communication/development disability and/or diagnosis of severe/profound MR Individuals meeting three of the above criteria were ranked Priority I, those meeting two criteria were ranked Priority II, and those meeting one criterion were ranked Priority III. Fifty-one individuals lacked a Legally Authorized Representative (LAR). Of those, 18 (35%) were ranked as Priority I (compared to four people identified as at high need at the last ranking), 21 (41%) were ranked Priority II, and 12 (24%) were ranked Priority III. The criteria used for this ranking were similar but not identical to the criteria in the draft DADS Guardianship/Advocate policy. When that policy is finalized and implemented,	Noncompliance

#	Provision	Assessment of Status	Compliance
		RGSC will need to revise its policy and criteria. Thus, although the Facility had a process in place, the Monitoring Team cannot find compliance until it is clear that the criteria and process match requirements of DADS policy. Furthermore, the criteria established by RGSC did not reflect consideration of capacity to render a decision that includes use of any accepted process or tool to assess capacity.. The draft DADS policy does not refer to use of such a process or tool. The PSTs were not using an individualized assessment process to determine that an individual was in need of an LAR, or to what extent or for what discrete purposes guardianship was required. The Monitoring Team reviewed PSPs for Individuals #5, #17, #27, #47, #54, #77, #98, #107, #133, and #149 to determine what the PST documented about review of and decision about need for guardianship. For three of ten PSPs (30%), there was evidence that a discussion had been held about ability to make choices. Three (30%) simply documented the individual was an adult without a guardian. For two (20%), no comment was made. One (10%) reported the individual would benefit from an advocate, and one (10%) reported the individual had an advocate. Although 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. Although progress had been made in ranking need for guardianship, the Facility will need to establish a more thoughtful process for the PST to assess capacity and identify the need for assistance with decision-making (and in what areas assistance is needed), and a process based on statewide policy will need to be implemented for prioritizing individuals.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of	Guardianship had been established for four individuals since the last compliance visit. One of those was established for a person upon admission to the Facility. For the other three, guardianship had expired and was renewed. Other than the newly admitted individual, no new guardian was obtained for any individual. Nevertheless, the HRO had begun initiatives to recruit guardians. She reported she was attempting to get on the agenda of the Facility's family association to seek volunteers. She was continuing to seek lawyers who would provide assistance for renewal of guardianships on a pro bono basis. She kept a tracking log of contacts; this included contacts to renew guardianships. Although the HRO reported attempts to identify communities that might provide resources for guardianship, there was not evidence of a structured and active recruiting effort with community groups and service organizations. This was appropriate, as state policy had not yet been implemented; establishment of state policy would provide guidance that might be needed to answer questions and	Noncompliance

#	Provision	Assessment of Status	Compliance
	individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	establish priorities. 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 zero of the PSPs reviewed (0%), there were specific action plans to address the individuals' capacity to make informed decisions. One way to provide opportunity to learn decision-making skills is through participation in a self-advocacy council. The Advocates meeting provides a venue to do this. The Monitoring Team attended a meeting of the Advocates. It was well-attended due to significant effort on the part of the HRO to encourage attendance. Once state policy is implemented, the Facility can move toward compliance by establishing a structured and active program to recruit guardians for people ranked at high priority.	

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. 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 and should discuss this issue as part of PSP planning.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Plan of Improvement (POI), dated 8/9/11 2. DADS Policy 020.1 Recordkeeping Practices revised 3/5/10 3. RGSC SOP HIM 400-07 Documentation Guidelines revised 7/15/11 and training sign-in sheets 4. RGSC SOP HIM 400-20 ICF-MR Monthly Record Review revised 6/14/11 5. RGSC SOP ICF/MR 400 14 Medical Care revised June 2011 and notification email from Lorraine Hinrichs to medical staff with read receipts 6. RG SOP EC 403 05 Hand Hygiene/Hand Washing Frequency revised December 2010, training materials, and sign-in sheets 7. Document titled DADS Policy and Procedure Tracking Tool (undated); table included RGSC revision dates 8. Process for Approving Policies (flowchart) 9. ICF Monthly Delinquent Assessment Report for 6/1/11-6/30/11 10. Training/Course Sign-In Sheets for • Protection from Harm--ANE Policy Changes • Revised Incident management Policy 11. Delinquent Recommendation email • Policy #ICF MR 200 08 and ICF MR 200 03 12. Curriculum/handout for Manual Mania and Survey Survival Guide training session 13. Settlement Agreement Provision V.4—Interview Tool for use of the Record forms completed 7/21/11 14. Share Drive assessment folder for Individual #91 15. Tables of Contents for Active Record (Active Record Order and Guidelines), Individual Notebook, and Master Record 16. Active Record, Individual Notebook, and Master Record for Individual #140 17. Active Record and Individual Notebook for Individual #1 18. Active Record for Individual #51 19. Numerous progress notes for several individuals from Clinical Work Station (CWS) 20. Active Record Audit Tools (completed by Facility) for Individuals #3, #15, #26, #33, #72, #80, #94, #118, #126, #133, and #134 21. Action/Corrective Action Reporting Document for July 2011, including "Pending Deficiencies" 22. Several emails tracking corrective action plans (CAPs) arising from records audits **People Interviewed:** 1. Leticia Gonzalez, RHIT, Health Information Management Director, and Melissa Canales, RHIT, Unified Records Coordinator **2.** David Moron, M.D., Clinical Medical Director **3.** Mary Ramos and Lorraine Hinrichs joint interview regarding policy development **4.** Vicky Martinez, Home Supervisor **5.** Joint interview of all QMRPs

	6. Interviews of PT, SLP, and NOO, regarding use of the Record **Meeting Attended/Observations:** 1. PSP Annual Planning Meeting for Individual #140 2. Quarterly PSP Review meeting for Individuals #39 and #74 3. Risk meeting for Individuals #40 and #80
	Facility Self-Assessment: RGSC reported it had not yet come into compliance with any provision of this section. The Monitoring Team concurs. The Facility identified a number of actions it had taken to improve and move toward compliance. These included revising policies and implementing or updating audit tools (such as the record audit and the V4 Interview tool) and procedures or tools for tracking status (such as the Delinquent Record Report). The Monitoring Team confirmed that these actions had taken place. However, these were simply a set of isolated actions rather than a sequential set of actions designed to move from current status toward compliance. For example, the Facility referenced in the POI only new and revised policies related to recordkeeping. However, several other policies had been implemented or revised. The Facility should develop a plan that encompasses all policy development needed for compliance with the SA.
	Summary of Monitor's Assessment: RGSC does not yet comply with any provision of this section. However, the Monitoring Team found improvement moving toward compliance in each provision. The Unified Record was in place and was generally organized so that documents could be found and used. However, documents in the record were not always current, and assessments were not completed and posted in a timely manner. An audit system was in place to review the Active Record and to identify and track completion of Corrective Action Plans (CAPs). Both individual and systemic actions have been implemented based on information from these audits. The audit system did not review the Individual Notebook, nor did it include all requirements of Appendix D of the SA. There was no evidence of a process to ensure that the data from the audits were accurate, such as an interobserver agreement process.; Agreement between the Monitoring Team and the Facility on one sampled record was in an acceptable range, but the Facility needs its own system to ensure continuing accuracy of audits. Policies necessary to implement all requirements of Part II of the SA were being developed, revised, and implemented but some remained to be developed. The Facility had recently initiated a survey process to assess use of the records in making decisions. The Facility did not yet include a broader process, although data were available that could be used in a more

	comprehensive review. Observations at meetings indicated that the records were often referred to; nevertheless, much information at the meetings involved reporting of impressions rather than data or other objective information from the record.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	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. RGSC SOP 400-07 guides documentation in the records. Although this policy was consistent with DADS Policy 020.1, some issues in that policy (such as falsification of records) referred to other facility SOPs. Furthermore, the SOP included information needed regarding documentation in the CWS. Since the last tour the Facility's record keeping practices continued to improve. Documents were organized, accessible, and it was easy to locate relevant information. The Monitoring Team reviewed the complete record for Individual #140, including the Active Record, Individual Notebook, Master Record, and a sample of CWS entries. The Monitoring Team reviewed the Active Record for Individuals #1 and #51 and the Individual Record for Individual #1. Although generally legible and in good order, each record had some errors in order or presence of documents, and some documents in each (100%) were not current. There were still a few gaps between entries, but only in one of three records (33%). Audits conducted by the Facility had similar findings. The Individual Notebooks were accessible. Separate books were present in the living and day activity sites. The Monitoring Team asked a home supervisor and a direct care staff to point out where to find the PNMP, data sheets, and other documents; the staff were able to go directly to those documents. However, in both notebooks, not all SPO data sheets were present. <u>Clinical Work Station</u> Documentation in the CWS was, of course, legible and readable. The presence of two separate systems remained problematic. To review progress notes, staff must open the CWS; if there is a need to cross-reference information in the Active Record with information in the progress notes, the Active Record must be brought to the computer	Noncompliance

#	Provision	Assessment of Status	Compliance
		area. The Integrated Progress Notes, which were organized chronologically and by discipline 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 an individual's clinical status. This posed a barrier to integrating clinical data to provide useful information. <u>Use of Share Drive</u> QMRPs demonstrated use of the Share Drive for posting and availability of assessments by PST members. The QMRP identified the required assessments. Per RGSC SOP 600 01, assessments are to be posted to the Share Drive 10 days prior to the annual PSP meeting for an individual. The QMRPs could easily navigate to the correct folder, identify which assessments were posted, and read them. For Individual #91, whose PSP annual meeting was to be held within 10 days, six assessments had been posted and eight had not been posted. In addition, the ICF Monthly Delinquent Assessment Report documented absence of numerous assessments in May and June 2011 including 24% of assessments due in June 2011. Although improvements had occurred in recordkeeping, compliance will require that records be current.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	Per interview with Mary Ramos and Lorraine Hinrichs, all policies are reviewed and updated annually. For facility-wide policies, the current policy (or a draft when a new policy is being developed) is sent to administrative staff and department heads, who are asked to provide recommendations by a due date. The recommendations are compiled, and a revision is drafted and sent to department heads; it then goes to the Professional Staff Organization meeting for review and approval. When a policy is revised, notice is typically sent to department heads, who are to disseminate to their staff. However, the Facility has not process to determine whether the policy was actually disseminated. The Facility provided the Monitoring Team with a number of policies revised since the last compliance visit, including: • RGSC SOP HIM 400-07 Documentation Guidelines revised 7/15/11 • RGSC SOP HIM 400-20 ICF-MR Monthly Record Review revised 6/14/11 • RGSC SOP ICF/MR 400 14 Medical Care revised June 2011 • RGSC SOP MR 700-14 The Use of Restraint revised 4/11 • RGSC SOP MR 200-02 Restrictive Practices revised 6/11 • RGSC SOP ICFMR 200-08 Protection from Harm – Abuse, Neglect, and Exploitation (revision date 6/11) • RGSC SOP ICFMR 200-03 Incident Management (revision date 6/11)	Noncompliance

#	Provision	Assessment of Status	Compliance
		• RGSC SOP ICFMR 400-01 Injuries to Consumers (revision date 5/11) For some policies, the Facility provided more extensive training on policy changes. The Facility provided sign-in sheets for training on abuse/neglect/exploitation/incident management (SOPs 200-03 and 200-08). Some policies did not yet provide the guidance needed to ensure compliance with all requirements of Part II of the SA. For example, although SOP ICF-MR 400-14 Medical Care was revised to require physicians to participate in interdisciplinary integrated planning, it did not address how or when the physician should inform the PST of diagnostic reports. Some policies still need to be developed. For example, other than the state policy, the Facility had not developed a localized PNMT policy that defined the roles and responsibilities of the PNMT and the collaboration that was intended to occur with the Personal Support Team (PST). There was not a defined criterion that stated what incidents must be referred to the PNMT and what may be referred to the PNMT. DADS was in process of developing statewide policies needed for compliance with Part II of the SA. One such policy was the guardianship and consent policy, which was in draft form. DADS and the Facility should continue to complete and revise policies to meet the requirement of this provision.	
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.	The process to audit records had continued to evolve and improve. Procedures to audit records were found in SOP HIM 400 20. Audits are scheduled on the Active Record for each individual who had a PSP annual review in the month reviewed. If there were not five PSP annual reviews, additional records were to be sampled. Audit forms provided by the Facility documented audits of five records in each month. The Facility provided audits of Active Records but did not provide audits of Individual Notebooks or of documentation in the CWS. There was no evidence of a process to ensure that the data from the audits were accurate, such as an interobserver agreement process. The Facility did not provide information on how reliability of the data in the audits was evaluated (such as whether there were independent audits of the same records). The Monitoring Team audited one record (Individual #1) that had been audited during August by the URC. Although there had been opportunities for corrective actions to have been taken, this was seen as an estimate of the reliability of the data and accuracy of the definitions in the policy. Agreement between the Monitoring Team and URC audits was	Noncompliance

#	Provision	Assessment of Status	Compliance
		83% for all items including those listed as N/A. This indicates a likelihood that the definitions are adequate for review overall. It would be advisable for the Facility to develop a process for independent review of a sample of the audits to determine whether there is interobserver agreement. Most requirements of Appendix D were audited. The audit form had been revised so that a single form had places to document both the presence of each type of document on the Active Record Order and Guidelines (and a comment column where issues such as lack of current document could be noted) and Appendix D requirements. This format can provide information by section of the Active Record, which could help in providing information for systemic corrective actions. However, the audit forms did not include documentation of legibility or of the process to correct errors. These should be added to the form. SOP HIM 400 20 lays out the process for corrective action planning. It lists the facility staff who are to receive the results of the audits. It states that data will be trended by discipline and where these results will be provided. Information for trends was provided for two months in each report. That is not an adequate period to identify trends; the Monitoring Team recommends that a longer period be used as planned by the Facility, at least for the overall compliance (perhaps continuing to show information by discipline only for a shorter time in order to maintain readability and interpretability of the graphs). The Facility recognized this issue and indicated in interview that use of a new form had been initiated in March 2011, and the Facility had a plan to expand the period to trend information to 12 months as it continued to get new data. The Facility provided a document entitled Action/Corrective Action Reporting Document. It identified corrective actions required for Individual #134 as well as prior corrective actions for several individuals (identifying those that were cleared and those that had not yet been cleared). For Individual #134, the document provided by the Facility did not document corrective action requirements for all documentation found deficient on the audit. The process to follow up on the identified corrective actions could ensure that these are not overlooked and will get monthly follow up until they are resolved. These documents identified one systemic issue for which action had been taken; numerous records did not include current psychological evaluations, and the Facility had contracted with a psychologist to complete these. The Facility had noted two other systemic issues for which it had taken action. • For the CWS, a template had been developed for the annual physician's assessment; this was being piloted.	

#	Provision	Assessment of Status	Compliance
		• A process had been implemented to audit contracted and consultant services. The Facility also had begun to audit the presence of required assessments in the Share Drive and produced a Monthly Delinquent Assessment Report. This report was intended both to provide notice of delinquent assessments and to assist the Facility to identify disciplines for which improvement actions should be planned. To achieve compliance, audits must address the Individual Notebook and CWS. They must include all requirements of the guidelines in Appendix D. Data should also be trended for longer periods of time, and the data should be used to track the effectiveness of systemic improvement actions.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	The Facility had initiated a process to assess use of the records in making decisions. The process, which began July 2011 and therefore had only been done one time, involved an email survey of use of the record using a form developed by DADS. After completing the audit of records for the month, the URC selected one record that did not require a large number of CAPs. For that record, the URC emailed the survey form to each discipline on the PST and provided a due date of 15 days for the discipline staff to complete the survey. Six disciplines were asked to complete the survey based on reference to the specific individual's record; two had completed the survey (33%), and CAPs had been initiated for the other four. This survey was still in a very early stage, and there had been no opportunity to summarize and trend information. The Monitoring Team completed the survey in an interview format with several facility staff; these surveys referenced the questions in general, rather than specific to one individual's record. Although some responses to a question of how the record is used when making decisions about an individual were general, some provided specific information such as looking at data for progress, referring to the record during staffings, and reviewing progress notes from direct care staff. Of five interview documents recorded by the Monitoring Team for group and individual interviews, one (20%) stated needed documents were found in the record, three (60%) stated documents were usually found, and one (20) stated documents are sometimes found. All (100%) reported examples of way in which the staff interviewed used information for another discipline to help plan a treatment or intervention. The Monitoring Team will consider using the individual-specific process for this interview during future visits. Although this survey process has to potential to provide useful information, the Facility will need to define how responses can be categorized in order to track systemic information.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Other ways to assess use of the records are available. The Monitoring Team observed an annual PSP planning meeting, quarterly PSP reviews, and special risk meetings. At each of these meetings, the record was referred to; at two meetings, a computer in the meeting room was used to refer to information in the CWS. Nevertheless, much information in these meetings involved reporting of impressions of PST members without reference to data from the records. Furthermore, not all data were updated in time to be useful; for example, seizure data were not updated in the record daily, so current month data were not available for discussion and could lead to erroneous conclusions. Assessments done in preparation for the annual PSP planning meeting were not consistently posted to the Share Drive so that PST members could review them prior to the meeting, as reported in Provision V.1. The Individual Notebooks were available at both living and day activity sites, and these provided information that could assist staff in implementing correct treatment procedures and supports. As noted throughout the report, however, staff were often observed not attending to or implementing procedures as identified in the Individual Notebooks. The Facility had made progress both in making the records more useable, in actual use of the records, and in developing a process to evaluate and monitor whether records are being used. To demonstrate compliance, the Facility will need to demonstrate during planning and review meetings that information from the records (including data) is used routinely, and that information in records is used to ensure accurate implementation of planned supports and services. The Facility will need to improve the ease of integrating information from the CWS with the active record and of tracking individual status across disciplines in the CWS so health conditions and actions can be viewed in an integrated manner and through to resolution. In addition, the Facility will need to continue its new procedure to assess use of the record and document both what is learned from that process and how the information is used to make systemic improvements.	

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

1. Develop means to improve the ease of integrating information from the CWS with the active record and of tracking individual status across disciplines so that health conditions and actions to address them can be viewed in an integrated manner and through to resolution. (Provisions V.1 and V.4)
2. Ensure that all requirements of Appendix B, as well as the Individual Notebook, are included in audits of records.

3. Establish a means to ensure reliability of audit findings. (Provision V.3)

List of Acronyms

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACP	Acute Care Plan
ADOP	Assistant Director of Programs
ACP	Acute Care Plan
ADL	Activity of Daily Living
ADR	Adverse Drug Reaction
AED	Anti-Epileptic Drug/Automated External Defibrillator
AFO	Ankle Foot Orthotic
AIMS	Abnormal Involuntary Movement Scale
ANA	American Nurses Association
A/N/E	Abuse/Neglect/Exploitation
AP	Alleged Perpetrator
APC	Admissions/Placement Coordinator
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
AROG	Active Record Order & Guidelines
AT	Assistive Technology
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
CPR	Cardiopulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CSO	Campus Supervision Overnight

CTD	Competency Training and Development
CV	Curriculum vitae (resume)
CWS	Client Work Station
DADS	Texas Department of Aging and Disability Services
DCP	Direct Care Professional
DD	Developmental Disabilities
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DMID	Diagnostic Manual-Intellectual Disability
DNR	Do Not Resuscitate
DOJ	U.S. Department of Justice
DRO	Differential Reinforcement of Other Behavior
DRR	Drug Regiment Review
DSHS	Department of State Health Services
DSM/DSM IV TR	Diagnostic and Statistical Manual of the American Psychiatric Association
DUE	Drug Utilization Evaluation
EEG	Electroencepheloagram
EKG	Electrocardiogram
ER	Emergency Room
FA	Functional Analysis or Functional Assessment
FBA	Functional Behavior Analysis or Functional Behavior Assessment
FSPI	Facility Support Performance Indicator
FTE	Full Time Equivalent
FY	Fiscal Year
GERD	Gastroesophageal reflux disease
HCG	Health Care Guidelines
HCP	Health Care Plan
HIPAA	Health Information Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMP	Health Maintenance Plan
HOB/HOBE	Head of Bed/Head of Bed Elevation
HRC	Human rights committee
HRO	Human Rights Officer
HST	Health Support Team
HT	Habilitation Therapy
IBW	Ideal Body Weight
IC	Infection Control
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICF/DD	Intermediate Care Facility for Persons with Developmental Disabilities
ID/DD	Intellectual Disability/Developmental Disability
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder

IMC	Incident Management Committee
IMRT	Incident Management Review Team
IPN	Integrated Progress Note
ISP	Individual Support Plan
i.v./IV	Intravenous
LAR	Legally Authorized Representative
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MBSS	Modified Barium Swallow Study
MD/M.D.	Medical Doctor
MOSES	Monitoring of Side Effects Scale
MR	Mental Retardation
MRA	Mental Retardation Authority
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphyloccus Aureus
NA	Not Applicable
NANDA	North American Nursing Diagnosis Association
NCP	Nursing Care Plan
NDC	Non Direct Care
NEO	New Employee Orientation
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NP	Nurse Practitioner
O2	Oxygen
O2Sat	Oxygen saturation
OCD	Obsessive Compulsive Disorder
OIG	Office of the Inspector General
OJT	On the Job Training
OT	Occupational Therapy
OT/OTR	Occupational Therapist, Registered
PALS	Positive Adaptive Living Survey
PAO	Physical Aggression toward Others
P&P	Policies and Procedures
P&TC	Pharmacy and Therapeutics Committee
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
PMOC	Psychiatric Medication Oversight Committee
PMR	Psychiatric Medication Review
PMT	Psychotropic Medication
PNA	Psychiatric Nursing Assistant
PNM	Physical and Nutritional Management
PNMC/PNMPC	Physical and Nutritional Management Coordinator/ Physical and Nutritional Management Plan Coordinator
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PO	By mouth
POC	Plan of Correction
POI	Plan of Improvement
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapy/Physical Therapist
PTR	Psychiatric Treatment Review
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QI	Quality Improvement
QMRP/QDDP	Qualified Mental Retardation Professional/Qualified Developmental Disabilities Professional
RD	Registered Dietician
RN	Registered Nurse
r/o	Rule out
ROM	Range of Motion
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAM	Self-Administration of Medication
SFBA	Structural and Functional Behavior Assessment
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SO	State Office
SOAP	Subjective, Objective, Assessment/Analysis, and Plan charting method
SSLC	State Supported Living Center
SPCI	Safety Plan Crisis Intervention
SPO	Specific Program Objective
SQRA	Standard of Quality for Risk Assessment
SSLC	State Supported Living Center
STAT	Immediate

STD	Sexually Transmitted Disease
TB	Tuberculosis
TD	Tardive Dyskinesia
TIVA	Total Intravenous Anesthesia
UA	Urinalysis
UIR	Unusual Incident Review or Unusual Incident Report
UTI	Urinary Tract Infection
VCF	Virtual Client Folder
VDB	Verbally Disruptive Behavior
VNS	Vagal Nerve Stimulator
VRE	Vancomycin-resistant enterococcus
x/o	Rule out