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.

Substantial Compliance Ratings and Progress

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

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

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

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

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

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

Executive Summary

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, especially Angie Alejo, Myrna Wolfe, Claudia Lucio, Jessica Juarez, and Rosie Sanchez. They ensured the documents requested were available before, during, and after the visit. They coordinated arrangements for all the meetings and observations. Too many other staff to mention assisted in numerous ways.

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

General Comments

Population. Population of the Facility at the beginning of the compliance visit was 70 individuals.

Facility Self-Assessment. RGSC wrote its self-assessment following new guidelines from DADS. As indicated in each of the sections of the report below, this was a good first step. Overall, the new format should help guide the facility in moving forward and to help managers and clinicians develop the ways in which they assess the quality and depth of the activities in which they and their staff engage to meet the many items of each of the provisions of the Settlement Agreement. The self-assessment described the activities engaged in to assess status, results (in some cases including data on status of processes or on outcomes), and the self-rating and rationale for the rating. The Monitoring Team provides, in this report, many specific reviews of the self-assessments to assist the Facility to select appropriate activities and measures of status and to describe reasons for discrepancies in ratings between this report and the self-assessment. The Facility should consider how it might expand use of its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes.

In addition, RGSC provided for each Section of the Settlement Agreement provisions an Action Plan listing actions to be taken to move forward toward compliance. This report also provides some comments about the action steps in order to assist the Facility to review its plans and ensure they will lead toward compliance and will provide an organized approach that can coordinate with the self-assessment.

Changes in Environment and Groupings
The Facility has made a concerted effort to make changes to the living unit environments both by making physical improvements and by establishing smaller groupings of individuals. These changes have provided greater privacy and less distraction for medication administration, have made it possible to train staff to be more familiar with the individuals they support, and have provided quieter spaces where smaller numbers of individuals may gather for leisure activities. The Facility is early in this process and will need to resolve concerns that arise from changes in groupings, including ensuring other staff who may be pulled in to assist with a group or individual receive the training needed on those individuals' supports and services. The Monitoring Team commends the Facility for making this effort, which should result in improved services and more pleasant living environments.

Specific Findings

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

Restraints

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. Use of crisis intervention restraint was low and continued to trend down.

- Positive Practices and Improvements Made
  - RGSC used restraint for crisis intervention only four times since the last compliance review.
  - Progress in documentation related to medical restraints had improved significantly from that observed at the last review The administrative initiatives noted in the last two compliance reports 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.

- Improvements Needed
  - The Facility has done little to develop support plans to reduce reliance on medical restraint for those who still require it.
  - The Monitoring Team identified three instances of use of an abdominal binder. In two instances the physician order associated with this use indicated its use should have been considered a protective restraint by the Facility. The Facility apparently did not view this abdominal binder use as restraint. Consequently, none of the required administrative and clinical procedures associated with restraint use were followed.

Abuse, Neglect and Incident Management

Issues not noted in the last compliance review regarding the systems for abuse and neglect reporting and the incident management system at RGSC were found in this review. Seven components determined to be in substantial compliance at the last review are no longer in compliance and only one that was determined noncompliant last review has become compliant.

- Positive Practices and Improvements Made
  - 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 the investigation review process determined it was appropriate for the staff person to return to his/her normal assignment.
  - The internal management and monitoring systems in place at RGSC were self-identifying many instances of noncompliance, especially in areas where clear data parameters exist such as the timeframes associated with reporting, with initiating investigations, and with completing investigations.

- Improvements Needed
    - The frequency of late reporting of allegations of abuse and neglect is alarmingly high.
    - The IMRT process is in place and functions as a review body, meets daily, and its minutes reflect review of injuries, incidents, and investigation reports. Nevertheless, the review process does not always ask the type of questions that reflect critical thinking. Certain injuries that on their face seem suspicious were not always probed with the level of scrutiny one would expect.

Quality Assurance

Although no provisions were found in substantial compliance, the Facility made progress in several areas.

- Positive Practices and Improvements Made
    - The Facility had adopted a methodology for review of data referred to as CATW2. CATW2 refers to **C**heck, **A**sk, **T**hink, **W**hy, and **W**hat. This methodology was developed by the Facility to encourage those reviewing data reports to engage in critical thinking. The Facility is to be commended for the development of this methodology, as it should help facilitate the use of data in identifying systemic issues.
    - The Facility revised trend data to include longitudinal data; although this was too recent to evaluate for effectiveness and compliance, it was an important step.
    - The Facility maintained a written Quality Assurance Policy and Plan. The Plan was comprehensive and ample evidence existed that demonstrated the plan was being implemented. Many Corrective Action Plans (CAPs) 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 Facility put in place a system to identify the need for a CAP, track CAP assignments and completion status, periodically review CAP status, and require evidence to substantiate CAP completion.
- Improvements Needed.
    - Continued improvement in tracking, trending, and use of data remains necessary.
    - There was little evidence that the RGSC quality assurance process attempted to identify issues of a systemic nature that would require a broader organizational response.
    - The Facility was unable to describe any process to determine if a CAP was effective in remedying or reducing the problems originally identified.

Integrated Protections, Services, Treatments and Supports

The Monitoring Team found all provisions to be noncompliant. The Facility had made progress in a number of areas.

- Positive Practices and Improvements Made
    - There has been a significant increase in the number of individuals referred for movement.

    - The QDDP Coordinator had initiated processes to monitor and provide peer review of ISP facilitation.
- Improvements Needed
    - Members of the IDT were not completing assessments timely so IDT members could review the information prior to the ISP annual planning meeting.
    - Professionals did not consistently include in their assessments a determination of the appropriateness of movement to a more integrated setting.
    - Documentation in the ISP of preferences focused on preferred foods and activities but did not generally identify preferred lifestyles, and therefore did not lead to a focus on goals that would be functional in a more integrated setting or could overcome obstacles to movement.
    - Supports and services were not integrated into the ISP. Some essential supports, such as medical and PBSP actions, were not included in the ISP and remained as separate plans.
    - Strategies to achieve goals were not specified, and responsibility for implementation and monitoring was identified by position title rather than by name of the responsible individual.
    - Although there had been training for staff who participate in ISP development, there was a lack of competency-based training for staff who implement the planned strategies.

<u>Integrated Clinical Services</u>

The Facility had taken many steps toward providing clinical services in an integrated manner. Nevertheless, integrating planning and services across disciplines remained a challenge. Although Facility clinicians supported the need for integration, there were still not adequate processes in place to ensure it occurred.

- Positive Practices and Improvements Made
    - The Facility had assigned teams consisting of a QDDP and a Nurse Case Manager to share a caseload. This improved collaborative review and discussion.
    - A morning medical meeting that involved physicians, QDDPs, and Nurse Case Managers provided an opportunity for integrated discussion about individuals and the potential to address systemic issues.
    - The PNMT nurse attends ISP annual planning meetings.
    - Facility clinicians documented review of consultation recommendations from non-Facility clinicians through initials and entries into the IPN. A new consultation tracking system had been implemented that should help to ensure consultations occur as ordered, and that reports are reviewed.
- Improvements Needed
    - Medical assessments and PBSPs were absent from the ISP.
    - Assessments did not show evidence of consideration of information from different disciplines.
    - There was a lack of evidence of interdisciplinary involvement in plans to provide health and behavioral services.
    - Documentation of notice to the IDT for consideration of consultation recommendation was not evident.

Minimum Common Elements of Clinical Care

The Facility had no system to ensure assessments and interventions were provided or revised routinely and when there was a change in an individual's condition. The use of clinical indicators was not formalized, nor were clinical indicators used to identify areas for systemic improvement.

- Positive Practices and Improvements Made
  - The Facility was in substantial compliance with the requirement that all diagnoses be 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.
  - Interventions were not always implemented or revised timely based on either assessments or clinical indicators.
  - Although the Facility had, at the last compliance visit, reported it was in process of developing clinical indicators to be used in a system to monitor health status, there had not been progress in identifying and using clinical indicators.
  - Some assessments did not provide comprehensive evaluation of essential issues.

At-Risk Individuals

Progress in complying with this section of the SA was characterized as "slow" by RGSC administrative staff. Evidence reviewed by the Monitoring Team confirmed this. Little substantive progress, until very recently, had occurred in meeting the requirements of this section of the SA.

- Positive Practices and Improvements Made
  - The ICF Program Director who had recently initiated an administrative process that when fully and effectively implemented should lead to improved compliance.
- Improvements Needed
  - Assessments were inadequate to determine risk level.
  - At the ISP annual planning meeting observed, risk level ratings were changed appropriately based on discussion and clinical data supporting the change in levels, but the related Risk Action Plan was not completed at the time of the meeting.
  - RGSC did not adequately respond to individuals who had a change of health status that should have resulted in risk screening.
  - Risk plans did not document adequate integration between all the appropriate disciplines, as dictated by the individual's needs.

Psychiatric Care and Services

Quality of psychiatric services is high, but additional resources are needed, and there needs to be greater interdisciplinary team involvement and integration with psychology services.

- Positive Practices and Improvements Made
    - Psychiatric evaluations meet standards and are of high quality.
    - All newly admitted individuals were provided a Reiss Screen, which was well incorporated into their psychiatric assessment.
- Improvements Needed
    - With the exception of incorporating behavior data into the assessment process, the quality of psychiatric evaluations are of very high quality; however, behavior data must be integrated into the assessment and treatment process.
    - The Facility administers psychotropic medications in accordance with standards but did not provide adequate information about behavioral treatment programs to conclude that there were effective behavioral programs that might complement the use of medication intervention.
    - The Facility does not have a process to evaluate the need for pre-treatment sedation.
    - The Facility did not have a process whereby the psychiatrist participates in an IDT meeting, along with the psychologist, to determine the least intrusive and most positive interventions to treat behavioral or psychiatric conditions.
    - The Facility did does not meet regularly to assess and report on Individual or Facility wide use of polypharmacy, and did not conduct trends analysis with appropriate action plans to reduce polypharmacy.
    - MOSES and DISCUS assessments were not consistently completed timely and thoroughly.

Psychological services

The Facility no longer had a Board Certified Behavior Analyst (BCBA) on staff. There were areas in which the Facility had achieved progress but also several significant limitations.

- Positive Practices and Improvements Made
    - Nearly all individuals living at the Facility had been provided a Psychological Assessment report within the past year.
    - Many elements of the SFAs and PBSPs had also improved considerably.
    - Many elements of the data graphs were of high quality.
- Improvements Needed

- Documentation reflected that the collection of behavior data was often inadequate. The data that were available were frequently not used effectively in determining the outcome of interventions,
- The Facility had achieved no progress from the baseline site visit in the process of integrating psychological and psychiatric services.
- There was no indication of data reliability on the Progress Notes or other data summary documentation.
- Review of Structural and Functional Assessments (SFAs) revealed only minimal attention was directed toward integrating environmental functions of behavior and the symptoms of mental illness into the assessment process.
- It was not evident that assessments were based on current, accurate, and complete clinical and behavioral data.
- No individuals living at RGSC at the time of the site visit were participating in counseling, psychotherapy, or any psychological service other than a PBSP.

<u>Medical Care</u>
Overall, the provision of medical services has significantly improved. There are still a number of improvements and requirements of the Settlement Agreement that still need to be addressed effectively.

- Positive Practices and Improvements Made
  - Physicians are appropriately and promptly addressing acute medical issues, hospital follow-up care, documentation practice, and management of complicated chronic conditions.
- Improvements Needed
  - The Facility must address conditions common to individuals with developmental disabilities.
  - There needs to be improved integration of health care issues into the IDT process.
  - A significant issue limiting the ability of the Facility to improve health care is the lack of a functional, and accurate management system for clinical data, which will enable real time reports such as current diagnosis, updated problem lists, and enable rapid the query of clinical data elements.
  - The Facility has not effectively implemented the State's Medical Provider Quality Assurance Audit process.

<u>Nursing Care</u>
Although there were areas of improvement, the Facility did not yet reach compliance for any provision.

- Positive Practices and Improvements Made
  - The addition of a Nurse Educator permitted improvements in nursing training on established policies, procedures, and protocols.
- Improvements Needed
  - The Nursing Department needs to improve assessment, management documentation, and follow-up through to resolution of individuals' acute changes in status.

- The Nursing Department needs to individualize Health Maintenance Plans (HMPs) and Acute Care Plans (ACPs) to meet each individual's specific health care needs in relation to their identified risk ratings and active medical problems for which nurses are responsible for providing care. Often individuals' high and medium risk ratings and active medical problems for which nurses were responsible did not have a nursing diagnosis/problems listed or a HMP developed. Conversely, HMPs were found that did not have an adequate nursing diagnosis/problem corresponding to the HMP.
- Many acute changes in status that required nursing interventions did not have ACPs developed and implemented.
- Individuals were not consistently provided with adequate comprehensive assessments in response to acute changes in status or as part of annual assessments. Risk Action Plans did not consistently include measureable, observable, and realistic objectives for each action step to evaluate the effectiveness of the plan. Clinical indicators were not consistently included for each risk rating.
- The Facility had not adopted and implemented the Department of Aging and Disability Services, Medication Variance Policy, 053. Only the Medication Variance Report form was implemented.

<u>Pharmacy Services and Safe Medication Practices</u>
Pharmacy processes were not adequate to demonstrate compliance and did not reflect significant improvement since the last compliance visit.

- Improvements Needed
  - The Facility did not have an effective process to ensure that the pharmacist comprehensively reviews all new medication orders, and that appropriate diagnostics are reviewed, as clinically necessary, prior to dispensing medication.
  - The Facility does not have appropriate policies, procedures, or practices to effectively manage or provide the necessary oversight for the use of polypharmacy, Stat medication use, including chemical restraints and benzodiazepines.
  - The pharmacy department does not have an effective process to ensure appropriate physician action plan, or process to follow-up on pharmacy recommendations made to physicians.
  - Elevated DISCUS scores were not adequately represented on the QDRR, and appropriate pharmacy recommendations to the physician were not documented on the QDRR
  - Although nursing staff had made significant improvement with better identification, reporting and analyzing medication variances, the Facility's medication variance process, did not include a collaborative effort among physician, pharmacy and nursing services.

<u>Physical and Nutritional Management</u>

Little progress had been made in improving physical and nutritional management. Some new processes had been put into place but had not yet resulted in improvement in safety or implementation of plans.

- Positive Practices and Improvements Made
  - Frequency of the PNMT meetings had increased since the previous visit and at the time of the compliance visit was meeting weekly.
  - The Facility had assigned a full time nurse to the PNMT; this nurse assisted with ensuring methods of care were shared with the accepting staff in the event of a hospitalization as well as post hospitalization assessment.
- Improvements Needed
  - Physical and Nutritional Management Plans (PNMPs) were not clearly developed with input from all members of the IDT or reviewed consistently by the IDT.
  - A risk process was in place; 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.
  - Supports regarding the areas of oral care and medication administration were missing from the assessment process and were not comprehensively included in the PNMP.
  - PNMPs were not comprehensive due to the plans lacking information regarding oral care and medication administration strategies.
  - Staff was observed not implementing PNMPs or displaying safe practices that minimize the risk of PNM decline.
  - 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.

<u>Physical and Occupational Therapy</u>
Although staff were added through contracts and hiring, the Facility did not have a sufficient number to meet the needs of individuals. The Facility did not yet comply with any provisions of this Section.

- Positive Practices and Improvements Made
  - Assessments were completed in accordance to the schedule set forth by RGSC. The OT and PT completed annual assessments/updates collaboratively.
  - The Habilitation Department had developed a sensory room as well as a gym that assist in the development of more proactive programs to maintain and improve upper and lower extremity functioning (although the gym was not yet being utilized).
- Improvements Needed
  - Assessments were not being consistently completed in response to a change in status.

- Assessments were not comprehensive.
- Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills.
- Plans were not implemented as written and staff was not knowledgeable of the OT/PT plans.

Dental Services

The Facility provides dental services through use of community dentists. For the most part, the Nursing Department was responsible for maintaining the dental schedule, and a recently hired contract dental hygienist was responsible for implementing oral hygiene efforts at the living area. The Facility did not have a specific staff person assigned to oversee dental services and had difficulty providing information about dental care (such as who has been evaluated for the need for suction toothbrushing.

- Positive Practices and Improvements Made
  - The contract hygienist continues to work diligently on enhancing oral hygiene efforts at the living area.
  - The Facility continued to maintain a spreadsheet for scheduling dental appointments. Nursing services provided the scheduling services for the Facility. As soon as someone returns from the dentist, the return visit date is entered into the spreadsheet. The Living area is notified of pending dental appointments timely.
- Improvements Needed
  - There were no policies or practices that enable an understanding of the necessary supports and services required to ensure adequate oral health care.
  - Staff must enhance their ability to administer oral hygiene, and ensure individuals are provided necessary oral hygiene at their living area.
  - Although the Facility has a triage mechanism for dental emergencies, the Facility does not have a process to track dental emergencies, and were unable to provide a list of those who experienced a dental emergency during the previous six months.
  - RGSC does not have effective policies, procedures, and practices to ensure that appropriate dental desensitization and/or other methods to reduce the need for pharmacotherapy forms of sedation during dental treatment are implemented.
  - There was a lack of meaningfully integrating dental services into the IDT process and representing dental issues in the ISP.

Communication

Although the Facility had hired an additional Speech and Language Pathologist (SLP), the impact of the additional therapist had not yet been observed at the level of care. Not all individuals with identified speech or language difficulties were receiving

services. The number of communication devices had increased, but there was not yet evidence that these devices were consistently used.

- Positive Practices and Improvements Made
  - The Facility had hired an additional SLP since the last compliance visit.
  - All individuals admitted since the last compliance visit received a communication assessment within 30 days of admission.
  - The number of shared Adaptive and Alternative Communication (AAC) devices had significantly increased across campus thus allowing greater access to said devices
- Improvements Needed
  - AAC devices were not consistently available, utilized, portable and functional in a variety of settings. DCPs interviewed were not knowledgeable of the communication programs.
  - The Communication Assessment did not consistently address expansion of current abilities and development of new skills.
  - There was no monitoring of communication devices or integration of communication programs and strategies into the ISP.

<u>Habilitation, Training, Education, and Skill Acquisition Programs</u>
Although efforts had been made to improve skill acquisition services, no provision showed improvement.

- Improvements Needed
  - Assessment findings and information in the ISP often did not agree.
  - Skill acquisition programs did not reflect that skill assessments or preferences of the individual had been considered in the development process.
  - The skill acquisition programs often failed to conform to accepted standards regarding task analysis.

<u>Most Integrated Setting</u>
The number of individuals referred for community living had grown significantly as a result of what the Facility described as a "paradigm shift" in which individuals' special needs are not seen as obstacles to movement but are instead identified as areas in need of additional supports. Observation of an ISP annual planning meeting and review of the referral list supported that this change had occurred. Given the growth in the referral list, there is a need for resources so that referrals can result in actual moves.

- Positive Practices and Improvements Made
  - The list of individuals being referred for movement to a more integrated setting had increased significantly.

- Improvements Needed
    - The Facility was continuing to implement actions to encourage individuals and LARs to move to the most integrated settings appropriate, but there had not yet been individualization of these actions. The Facility provided and encouraged tours of community settings but did not have a process in place to evaluate the effectiveness of these tours.
    - The identification of protections, services, and supports needed for provision of adequate habilitation in the most integrated appropriate setting needs improvement in order to ensure Community Living Discharge Plans (CLDPs) adequately reflect the needs of each individual for protections, supports, and services.
    - CLDPs were not always completed timely, in part because of delays in provision by professionals of required assessments.
    - CLDPs did not identify individual staff responsible for implementing or ensuring implementation of required supports.
    - Professionals did not consistently report in their assessments a determination of the appropriateness of movement to a more integrated setting.
    - The Facility reported that Post Move Monitoring visits have been made timely; however, documentation was not provided to the Monitoring Team, so it is not possible to find substantial compliance.

<u>Consent</u>

The Facility was awaiting implementation of DADS policy on guardianship but had used criteria in the draft policy in ranking need for guardianship. A ranked prioritization list had been updated. Creative efforts had been made to make available resources to assist families and advocates to apply for guardianship.

- Positive Practices and Improvements Made
    - The Facility had updated a ranked list and used criteria in the draft DADS policy to prioritize need for guardianship.
    - To ensure enhanced level of supervision (LOS) does not occur without HRC review, the HRO began to get a table each day that lists LOS; this table was also provided to QDDPs, supervisors, and DCPs so that they are all aware of current enhanced LOS assignments.
    - The Facility had recruited an attorney and judge to provide pro bono assistance and to reduce the cost to file guardianship applications, and had sent information out to families and advocates to inform them.
- Improvements Needed
    - Final DADS policy was not implemented at the time of the compliance visit. The policy was implemented the week following the visit.

- Neither the Facility nor draft DADS policy provided guidance about assessing functional capacity to make decisions or to identify the areas in which each individual is able to make informed decisions as well as those areas in which he/she cannot make such decisions.
- There was no evidence in ISPs for individuals without guardians that IDTs were discussing the need for guardianship in relation to the individual's ability to make decisions or give informed consent

Recordkeeping and General Plan Implementation

RGSC has continued improvement in all areas of this Section. Although no provisions were yet found in compliance, continuing improvement and attention to a few issues should make compliance possible.

- Positive Practices and Improvements Made
  - The Facility had a Unified Record for each individual.
  - The Facility has in place an audit process that has the potential for substantial compliance.
- Improvements Needed
  - Records were, for the most part, complete; however, a few items were consistently not found (and were noted both by the Monitoring Team and in the Facility's own audits as not present).
  - Facility policies do not yet address all requirements of Appendix D of the Settlement Agreement. In some cases, current practice did address requirements that were not yet found in Facility policy.
  - For both the Facility and DADS, many new and revised policies had only recently been implemented. Furthermore, there were instances identified throughout this report of lack of accurate implementation of policies, and the Facility does not have a process in place to track that.
  - Although the Facility record audit process included a recently-established interrater reliability review, some items on the audit tool were uniformly marked Not Applicable by both the primary and reliability auditors, even though they were often applicable and usually (but not always) in place.
  - Corrective actions arising from audits of records focused on errors in individual records and had not yet led to a focus on systemic improvements. Both types of corrective actions are needed.

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 Self-Assessment and Action Plan (AP) 2/13/12 2. RGSC Section C Presentation Book 3. DADS Policy 001-Use of Restraint 8/31/09 4. RGSC SOP MR 700-14 The Use of Restraint (4/11) 5. RGSC SOP MR 200-02 Restrictive Practices (6/11) 6. Crisis intervention restraint records prepared by the RGSC for Individuals #15 and #115 7. Medical restraint records prepared by the RGSC for Individuals #8, #75, and #139 8. Restraint Log 9/1/11 to 2/12/12 9. Restraint Trend Analysis through January, 2012 10. IMRT Minutes reflecting restraint review 11. Training records for sample of staff 12. Training records for sample of restraint monitors **People Interviewed:** 1. Lorraine Hinrichs, ICF-DD Program Director 2. Mary Ramos, Quality Management Director 3. Vanessa Villarreal, Associate Psychologist, Interim Director of Psychology **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 2/26/12 2. Settlement Agreement Performance Improvement Council (SA-PIC) 2/29/12
	Facility Self-Assessment: The Rio Grande self-assessment reported that the Facility was not in substantial compliance with six of seven provisions of this section of the Settlement Agreement (SA). The RGSC self- assessment reported substantial compliance with Provision C.3. Provision (C.7) was rated as not in compliance but the RGSC did not have any individuals who were restrained with sufficient frequency to trigger the requirements of the provision. The Facility's methodology for its self-assessment rating is described in each provision. For example, for Provision C1, the Facility stated it reviewed all four restraints identified as for crisis intervention and gave examples of two that did not meet requirements of policy, therefore rating noncompliance. Information from these reviews of restraints also resulted in a rating of noncompliance for Provisions C2 and C4. For Provision C3, the Facility reported that it reviewed specific training and policy, and found the provision in substantial compliance. However, this provision requires not only that policies be developed but also that they be implemented. The Monitoring Team did not find substantial compliance; this was primarily

	because the RGSC self-assessment focused compliance on adherence to staff training requirements and did not engage in self-assessment activity directed at policy implementation practices. 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. The frequency of restraint use at RGSC remained low (only four crisis intervention restraints since the last review) 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. The Facility also provided a document that reported actions being taken to achieve compliance. Nearly all of these action plans were described as "Ongoing" or "In Process" and had completion dates from 9/1/12 to 9/1/13. Most of these actions involved either providing or documenting training, auditing restraints (including auditing emergency restraints, which the self-assessment said was being done and was the basis for compliance ratings already, although the projected completion date was 3/31/13), or involved revising forms and checklists.
	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. Two of the four crisis intervention restraints were problematic. The problems associated with these two restraints were detected early through the restraint review process and corrective action planning occurred immediately. Crisis intervention restraint use at RGSC continued to trend down. RGSC used restraint for crisis intervention only four times since the last compliance review. In the prior review period crisis intervention restraint was used six times. Progress in documentation related to medical restraints had improved significantly from that observed at the last review; however, the Facility has done little to develop support plans to reduce reliance on medical restraint for those who still require it. 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. During this review period crisis intervention restraint was used four times. In the prior review it was used six times. The Monitoring Team identified three instances of use of an abdominal binder. In two instances the physician order associated with this use indicated its use should have been considered a protective restraint by the Facility. The Facility apparently did not view this abdominal binder use as restraint. Consequently, none of the required administrative and clinical procedures associated with restraint use were followed. The frequency of use of pre-treatment sedation remained low and was reported to be used in only 6% of

	dental procedures. The Facility does not use Total Intravenous Anesthesia (TIVA). The average number of medical restraints per month had decreased from nine per month reported in the last review to 6.6 per month since the last review. Most pretreatment sedation (88%) was for medical procedures. Pre-treatment sedation for dental procedures accounted for only 12% 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 two compliance reports 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 Monitoring Team would like to acknowledge the progress the RGSC has made in developing non-restraint strategies for addressing the needs of individuals. Not only has the frequency of restraint use declined, but the type of restraint used in three of four instances was less restrictive and of much shorter duration. The Facility's restraint review process worked particularly well in identifying two instances of inappropriate use of restraint. While the Facility is to be commended for its continued decrease in the frequency of use of restraint it is important that restraint, when used however infrequently, be used properly and in accordance with policy.

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C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an	The RGSC self-assessment reported lack of compliance with this provision of the Settlement Agreement (SA). The Facility engaged in the following activities in conducting its self-assessment. The self-assessment process included a review of Incident Management Review Team (IMRT) minutes for 100% of restraints used for crisis intervention. Restraint reviews included review of the Restraint Checklist (RC), physician orders, and the Face-to-Face Debriefing (FFAD) document, and, review of video surveillance tapes, when available, of the circumstances leading up to restraint use, and during the use of restraint. These reviews were conducted by the Psychology Department. The Facility's determination of noncompliance was based on its self-assessment review which identified two of four (50%) instances of crisis intervention that did not occur in accordance with Facility policy and this provision of the SA. In one restraint ((9/7/11) the RGSC self -assessment reports that video review of the restraint shows the person restrained did not pose an immediate and serious risk of harm to himself or others, a	Noncompliance

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	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.	graduated range of less restrictive measures were not exhausted or considered in a clinically justifiable manner, and, that the individual was held in a supine position. In the other noncompliant restraint an emergency chemical restraint was implemented without consultation with the Psychology Department, a violation of a Facility policy that is in place to ensure restraint is only used in a clinically justifiable manner. The Monitoring Team review of this restraint also determined that there was insufficient documentation to validate that the person restrained posed an immediate and serious risk of harm to himself or others. The Monitoring Team review of documents validated this self-assessment and the Monitoring Team concurs with the Facility's determination that it is not in compliance with this provision of the SA. RGSC SOP ICFMR 700-14 The Use of Restraint (4/11) and RGSC SOP MR 200-02 Restrictive Practices (6/11) guide facility practices with respect to restraint use. These policies addressed the requirements mandated by the State policy, are comprehensive, and directed to the practices necessary to achieve compliance with the Settlement Agreement. Crisis intervention restraint use at RGSC continued to trend down from that reported in the last review. There were only four instances of crisis intervention restraint (involving two Individuals) since the last review. In the prior review period crisis intervention restraint was used six times. The Monitoring Team reviewed all four restraint episodes. This will be referred to as Sample C.1 throughout this report. Use of medical restraint also continued at a low rate. Medical restraint for dental procedures was reported as used in only 6% of procedures and the Facility reported no use of TIVA. The Monitoring Team requested that documentation files be prepared for each instance of restraint in each sample that included at least the following: • Medical Restraints – the restraint checklist, face to face debriefing documents, medical orders, physician specified monitoring schedule, standard facility 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	

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		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. There was, however, an instance of restraint applied to an individual in a supine position, which is inherently dangerous and prohibited by policy. This occurred on 9/7/11 with Individual #115. This restraint episode was reported to the Department of Family Protective Services (DFPS) as an allegation of physical abuse and, after investigation, DFPS made a determination of confirmed abuse. <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. 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 two of four restraint records reviewed (50%), 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 #115 (9/7/11) did not describe behavior on the Restraint Checklist (RC) that would indicate the individual posed an immediate	

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		and serious threat to self or others. When this restraint was reviewed by the Psychology Department they determined restraint was used even though the individual did not pose an immediate and serious threat to self or others. The Facility is to be commended for implementing a restraint review process that was sufficient in scope and depth to identify this issue. Emergency chemical restraint of Individual #15 on 9/20/11 was in response to what was described on the restraint checklist as "agitation, yelling, crying for over an hour." This was insufficient to determine that the Individual posed an immediate and serious threat to self or others. Upon review, the Psychology Department determined this restraint violated policy because the psychologist was not consulted prior to restraint. Had the Psychology Department been consulted prior to the chemical restraint occurring, the Psychology Department reported it would have been unlikely that there would have been a decision that the behavior of the individual posed an immediate and serious threat to self or others, and instead other intervention strategies would have been deployed. This was further documented in the Incident Management Review Team (IMRT) minutes of 9/21/11. In two of four (50%) 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 exceptions were the restraint of Individuals #15 and #115 (9/7/11) described above. Two of the four restraint records reviewed (50%) 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 exceptions were the restraint of Individuals #15 and #115 (9/7/11) described above. For the other two restraints this requirement was documented on restraint checklists; however, in each case the only intervention documented was "redirection." Both restraints occurred back to back when the individual was attempting to open the door of a moving van. In this instance, staff had to act quickly to avoid a potentially tragic accident and the use of multiple intervention strategies would not have been appropriate. 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. As noted above, for two restraint of four (50%) the Facility was unable to validate, through its restraint review process, that sufficient clinical justification existed for the use of restraint. 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	

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		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 prepared by the Facility for review 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 prepared by the Facility for review 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 four restraints three (75%) were restraints approved in policy. The one that was not was the restraint of Individual #115 (9/7/11) that included restraint in a supine position.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The RGSC self-assessment reported lack of compliance with this provision of the Settlement Agreement (SA). The Facility engaged in the following activities in conducting its self-assessment. The self-assessment process included a review of Incident Management Review Team (IMRT) minutes for 100% of restraints used for crisis intervention. Restraint reviews included review of the Restraint Checklist (RC), physician orders, and the Face-to-Face Debriefing (FFAD) document, and, review of video surveillance tapes, when available, of the circumstances leading up to restraint use, and during the use of restraint. These reviews were conducted by the Psychology Department. The RGSC self-assessment reported lack of compliance with this provision of the Settlement Agreement (SA). This was primarily because the RGSC self-assessment of restraint practices and documentation identified one instance of four (25%) where restraint was not terminated as soon as the individual was no longer a danger to himself or others. The four restraints reviewed by the Monitoring Team consisted of three physical holds of	Noncompliance

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		four, five, and seven minutes and one chemical restraint. In the last review the Monitoring Team noted that all six instances of restraint use were horizontal side-lying physical restraint, one of which lasted 21 minutes and another 46 minutes. The Monitoring Team would like to acknowledge the progress the RGSC has made in developing non-restraint strategies for addressing the needs of Individuals. Not only has the frequency of restraint use declined, but the type of restraint used in three of four instances, was less restrictive and of much shorter duration. The restraint release circumstances associated with these four restraints, and documented on the RCs, were: • Individual #115 (9/7/11): seven-minute personal hold which included holding the individual in a supine position. The restraint ended when the restraint monitor arrived and instructed staff to release. The RC did not include a legible release code. The FFAD noted the restraint technique was not applied correctly and according to PMAB training. The review of this restraint reported the individual was not released when no longer considered a danger to himself or others. • Individual #115 (11/25/11): this individual was restrained back to back, 20 minutes apart. Both restraints were physical holds. The first restraint lasted five minutes and the release code was P –"released immediately because no longer an immediate and serious risk of harm to self/others." The second restraint began 20 minutes after the first restraint ended and lasted four minutes. The release code was P –"released immediately because no longer an immediate and serious risk of harm to self/others." The fourth crisis intervention restraint was a chemical restraint for which application of this provision would not be applicable. Additional documentation reviewed by the Monitoring Team, including the FFAD and PSPA documents (where provided), further validated the data presented on Restraint Checklists. Finally, the Monitoring Team identified three instances of use of an abdominal binder. In two instances the physician order associated with this use indicated its use should have been considered a protective restraint by the Facility. The Facility apparently did not view this abdominal binder use as restraint. Consequently, none of the required administrative and clinical procedures associated with restraint use were followed, including procedures necessary to comply with this provision of the SA.	

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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 self-assessment reported substantial compliance with this provision of the Settlement Agreement (SA). The Facility engaged in the following activities in its self-assessment: • Reviewing staff training delinquency reports • Reviewing Policy 700-14 Use of Restraint The Facility's self-assessment of this provision did not include an assessment that policies governing the use of restraint were implemented according to policy. As described in Provisions C.1 and C.2 the Monitoring Team identified policy implementation issues that would preclude a finding of substantial compliance for this provision. To achieve compliance with this provision of the SA the Facility must demonstrate not only the completion of required training, but implementation that is consistent with policy. Review of the DADS training curricula used by the facility demonstrated that it included adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. 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: • PBS0100 Positive Behavior Support • PMA0320 PMAB Basic • PMA0400 PMAB Restraint • PMA0700 PMAB Prevention • RES0105 Restraint: Prevention and Rules for Use at MR Facilities The Facility may want to consider a revision to its restraint policy to identify the specific training classes it requires of staff to be considered competent in restraint use and application. The Monitoring Team expects that all classes are to be taken pre-service and every 12 months thereafter. In reviewing RGSC training records it does not appear the Facility requires PBS0100 be taken at 12 month intervals. Fifty-two percent of the sampled	Noncompliance

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		employees referenced below had not taken PBS0100 within the last 12 months. A primary source of training documentation used by the Monitoring Team is a State report (MHMR0102) titled "Percent of All Employees Completing Courses of Training". This report will indicate, for each training class, the number of employees at the Facility required to complete a particular course, and the percentage that had taken the course, as of the date the report is produced. For example, the report provided to the Monitoring Team was produced on 2/1/12. It reports that RGSC had 483 employees required to take ABU0100, Abuse, Neglect, Exploitation and that 100% of the 483 employees were current in this training. This report was not useful to the Monitoring Team this review for two reasons. • First, data associated with important classes related to this section of the SA were not included on the report including RES0105 (Prevention and Use of Restraint), and PBS0100 (Positive Behavior Support). It was also noted the report did not include UNU0100 (Unusual Incidents) which is relevant to Section D of the SA. • Second, some data appeared to be obviously incorrect. For example, the report indicates 295 employees are required to take PMAB Basic but only 68 are required to take PMAB Restraint and PMAB Prevention. At a minimum all Direct Care Professionals are required to take all three classes. This report (MHMR0102) is viewed by the Monitoring Team as a primary tracking tool of Facility compliance with training requirements and needs to be complete and accurate. The Monitoring Team chose a sample of 25 employees for review of training transcripts. Twenty-two were selected randomly. The other three were the only staff actually involved in restraint since the last review. 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: 13 of 25 (52%) had completed this training within the last 12 months. • 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: 25 of 25 (100%) had completed this training within the last 12 months.	

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		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 the training elements of this provision of the SA. In the last report the Monitoring Team noted that in addition to this required training the RGSC had created facility-specific competency-based restraint training for 1) IDT members, 2) direct care professionals, 3) nursing staff, and 4) staff serving as restraint monitors. This training, and the accompanying competency checks, were noted to provide useful facility-specific training to supplement the required State level training classes. It was unclear as to if this facility-specific training was still being offered on a continuing basis. Changes in leadership of the Psychology Department may have impacted this. If this training has been discontinued the Facility should consider its re-initiation. While the Facility is to be commended for its continued decrease in the frequency of use of restraint it is important that restraint, when used however infrequently, be used properly and in accordance with policy. As noted in Provision C.1 two of four (50%) restraint records reviewed showed that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	The RGSC self-assessment reported lack of compliance with this provision of the Settlement Agreement (SA). The Facility engaged in the following activities in conducting its self-assessment. The self -assessment process included a review of Incident Management Review Team (IMRT) minutes for 100% of restraints used for crisis intervention. Restraint reviews included review of the Restraint Checklist (RC), physician orders, the Face-to-Face Debriefing (FFAD) document, and, review of video surveillance tapes, when available, of the circumstances leading up to restraint use, and the use of restraint. The Facility's determination of noncompliance was based on its self-assessment review, which identified that one of the four crisis intervention restraints reviewed did not occur in response to a behavioral crisis. The review conducted by the Monitoring Team validated the accuracy of the RGSC self-assessment and identified areas of required compliance not addressed by the RGSC self-assessment. The RGSC self-assessment did not address any methodology from which it could determine compliance with the requirement that "No restraint shall be used that is prohibited by the individual's medical orders or ISP." The RGSC self-assessment also did not address any methodology from which it could determine compliance with the	Noncompliance

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		requirement that "If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint". The Facility noted in response to the pre-visit document request that it did not have any support plans in place to address this last point. Nevertheless, a self-assessment process should address each SA topic. In this case the RGSC self-assessment could have reported "in 40 of 40 medical restraints reviewed the Individuals ISP did not include treatments or strategies to minimize or eliminate the need for restraint." From a review of four crisis intervention restraint records (Sample C.1), two (50%) included evidence documenting that restraint was used as a crisis intervention. The exception was the restraint of Individuals #15and #115 described earlier in this report. In addition, the Monitoring Team identified three instances of use of an abdominal binder. In two instances the physician order associated with this use indicated its use should have been considered a protective restraint by the Facility. The Facility apparently did not view this abdominal binder use as restraint. Consequently, none of the required administrative and clinical procedures associated with restraint use were followed, including procedures necessary to comply with this provision of the SA. Documentation prepared by the Facility and provided to the Monitoring Team for the four crisis intervention restraints 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. Similarly, no data was presented regarding any restraint limitations noted in a PSP. Therefore, the Monitoring Team could not determine whether any restraints used were prohibited by medical orders. The Facility, in the pre-visit document request, presented a form titled "Considerations for Implementing Restraint Medical/Physical "which, if used, would adequately document compliance with these components of this part of this provision of the SA. The Interim Psychology Director reported that this form was not yet in use. In prior compliance reviews the Monitoring Team noted that Facility initiated improvements had significantly decreased the need for pretreatment sedation (medical restraint). This included the recruitment of new medical/dental providers in the community. These providers were more willing to work with RGSC individuals without pretreatment sedation. Additionally, RGSC was using a portable dental operatory stationed on its campus to prepare individuals for the experience of a visit to the dentist. 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	

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		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. These practices have resulted in only 6% of dental procedures requiring pre-treatment sedation. The frequency of use of pre-treatment sedation has decreased since the last review. The medical restraint log submitted with the pre-visit document request report reported the use of 33 medical restraints over a five-month period, an average of 6.6 per month. This is a decrease from the nine per month noted in the last review report. Most pre-treatment sedation (88%) noted on the log was for medical procedures. Pre-treatment sedation for dental procedures accounted for only 12% 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 IDTs 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 ten instances of medical restraint that occurred since the last review. All ten were pre-treatment sedation. None of the documentation files prepared by the Facility for review by the Monitoring Team included a Specific Program Objective (SPO), or other documentation, that described a formal effort to reduce the need to use pretreatment sedation with those individuals. This further supports the view of the Monitoring Team that IDTs 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	The RGSC self-assessment reported lack of compliance with this provision of the Settlement Agreement (SA). The Facility engaged in the following activities in conducting its self-assessment. The self-assessment process included a review of Incident Management Review Team (IMRT) minutes for 100% of restraints used for crisis intervention. Restraint reviews included review of the Restraint Checklist (RC), physician orders, and the Face-to-Face Debriefing (FFAD) document, and, review of video surveillance tapes, when available, of the circumstances leading up to restraint use, and during the use of restraint. Physician orders were reviewed for 40 of 40 medical restraints (100%). These reviews were conducted by the Psychology Department. The Facility's determination of noncompliance was based on its self-assessment review which identified that none of the 40 medical restraints reviewed included a physician-specified type of required monitoring.	Noncompliance

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	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 Monitoring Team detected issues with the proper completion of FFADs completed by the Restraint Monitors. These are described below. The RGSC self-assessment should have identified these kinds of issues and presented them in summary form in the RGSC self-assessment document. Review of Facility training documentation showed that there were adequate training curricula on the application and assessment of restraint. 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 not always complete, descriptive, and describing the restraint episode in a manner consistent with other documentation such as the Restraint Checklist and PSPAs. For example, the restraint of Individual #115 is noted on the RC as a physical hold of the arm. On the FFAD, completed by a Restraint Monitor, it is noted as a basket-hold restraint. The FFAD notes the RC is completed correctly even though the RC does not include an entry in the box where level of supervision is to be noted. The Facility provided the Monitoring Team with a list of staff designated as Restraint Monitors. Three were selected for review of training requirements. These three were selected because they were the only staff performing restraint monitor duties since the last review. 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 three restraint monitors in the sample successfully completed. All three restraint monitors had completed all required training. There was one instance were training had not occurred within the prescribed 12 month interval. Two of the three	

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		(67%) were not current with PBS0100. All four restraint documentation files contained an FFAD. None were completed 100% correctly. For example, the FFAD for Individual # 115 did not record the time the restraint monitor arrived. It also reported the RC checklist was completed correctly when it was not. The FFAD for Individual #15 reported as "N/A" such items as "person's behavior an immediate and serious risk of harm to self or others?" and "graduated range of less restrictive measures exhausted or considered in a clinically justifiable manner before restraint? Psychologist contacted for alternatives prior to chemical?" The circumstances associated with this restraint clearly called for a yes/no response, not an N/A response. The Facility needs to ensure restraint monitors are engaged in critical thinking when reviewing the restraint episode and recording data on an FFAD document. In four instances (100%), 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 adequate assessment was completed of the circumstances of the restraint. There were brief entries in section 3 of the FFAD and occasional notations in other parts of the FFAD. These entries typically 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 information was contained in the PSPA and IMRT meetings that reviewed the restraint episode but this component of this provision of the SA requires a level of review by the restraint monitor who arrives within 15 minutes that would be more substantive than what was recorded on the four FFADs reviewed by the Monitoring Team. None of the four crisis intervention restraint records in the sample indicated an alternative physician-ordered monitoring schedule. Based on a review of four 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 (50%) restraints. Listed below are the individuals and dates of the restraint record where this did not occur: o Individual #115: 11/25/11 at 1:00 pm. Individual #115 was not monitored until one hour after the restraint was initiated. o Individual #15: 9/20/11 at 6:10 p.m. Individual #15 received a chemical restraint. There was no Physician Order's for monitoring. According to DADS Use of Restraint Policy, "A licensed health care professional must monitor and document vital signs, respiration,	

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		circulation, and mental status (orientation to person, place, and time compared to what is normal for the individual, and level of consciousness) of the individual in physical and mechanical restraint at least every 30 minutes and chemical restraint at least every 15 minutes from the start of the restraint for at least two or more hours." ▪ Monitored and documented vital signs in three (75%). Records that did not contain documentation of this included: Listed below are the individuals and dates of the restraint record where this did not occur: o Individual #115: 11/25/11 at 1:00 pm. Individual #115's vital signs were not monitored until one hour after the restraint was initiated. o Individual #15: On 9/20/11 at 6:10 p.m., Individual #15 received a chemical restraint. After reasonable effort by the nurse to assess blood pressure and respirations every 15 minutes, Individual #15 refused, except for one 15 minute interval. Attempts to assess vital signs were completed every 15 minutes for the first hour of restraints, thereafter vital signs were attempted every 45 minutes for the last hour of restraint. ▪ Monitored and documented mental status in three (75%). Listed below is the individual and date of the restraint record where this did not occur: o Individual #115: 11/25/11 at 1:00 pm. Individual #115's mental status was not monitored until one hour after the restraint was initiated. Based on documentation provided by the Facility, zero restraints had occurred off the grounds of the Facility in the last six months. 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. From the documentation files prepared by the Facility for review by the Monitoring Team the following determinations were made: In none of the ten (100%) medical restraints reviewed did the physician specify the schedule and type of monitoring required. This confirms the finding in the RGSC self-assessment. None of the ten (100%) medical restraints in the sample indicated an alternative monitoring schedule or type ordered by the physician. All ten incidents of medical restraint were chemical restraint. Two restraints (Individual #8 – 1/5/12 and Individual #75 9/8/11) did not include a physician order specific to the medical/dental procedure for the chemical restraint.	
C6	Effective immediately, every	The RGSC self-assessment reported lack of compliance with this provision of the	Noncompliance

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	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.	Settlement Agreement (SA). The Facility engaged in the following activities in conducting its self-assessment. The self-assessment process included a review of Incident Management Review Team (IMRT) minutes for 100% of restraints used for crisis intervention. Restraint reviews included review of the Restraint Checklist (RC), physician orders, and the Face-to-Face Debriefing (FFAD) document, and, interviews with three shift supervisors, one QDDP, and two nurses to determine the level of supervision during medical restraint. This review was conducted by the Psychology Department. The results of the RGSC self-assessment reported 100% of checklists included documentation the individual was checked for injury, and 100% of physical hold restraint included 1:1 supervision of the individual. The Monitoring Team determined that 100% of checklists included documentation the individual was checked for injury, but none of the checklists documented 1:1 supervision. The RGSC self-assessment also reported that interviews with nursing staff, shift supervisors, and QDDPs indicated that individuals receiving pre-treatment sedation receive 1:1 supervision until discontinued by nursing but that no documentation was found to support or provide evidence of that practice. Similarly, the Monitoring Team found no evidence in this regard. The RGSC self-assessment concluded noncompliance with this provision primarily due to the lack of evidence of 1:1 supervision for individuals who receive chemical medical restraint. The Monitoring Team concurs. A sample (Sample C.1) of four 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 none (0%), continuous one-to-one supervision was documented. • In four (100%), the date and time restraint was begun was documented. • In three (75%), the location of the restraint was documented. • In two (50%), information about what happened before, including the change in the behavior that led to the use of restraint was adequately documented. • In four (100%), the interventions taken by staff prior to the use of restraint were adequately documented and are adequate for post restraint review. • In three (75%), 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 IMRT review the specific reason for the use of restraint was apparent in all four (100%) cases. • In four (100%), the method and type (e.g., medical, dental, crisis intervention) of	

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		restraint was indicated on the restraint checklist. • In four (100%), 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 staff while the individual was in restraint, including: • All four were of short duration. None required observations at least every 15 minutes and none required that the specific behaviors of the individual that required continuing restraint be noted. • Because of the short duration of restraint episodes 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 four (100%), the level of supervision provided during the restraint episode was not recorded on the restraint checklist. • In four (100%), the date and time the individual was released from restraint was recorded on the restraint checklist. • In four (100%), 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. • In four records (100%) restraint debriefing forms (FFADs) had been completed. • Crisis intervention chemical restraint of Individual #15 was included in Sample C.1. The documentation for the restraint of Individual #15 did not include an "Administration of Chemical Result Consult" but did include the required "Chemical Restraint Clinical Review" which is part of the FFAD process, although the physician portion of this review was not completed until one month after the chemical restraint occurred.	
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 self-assessment reported lack of compliance with this provision of the Settlement Agreement (SA) because the Facility did not have any Individuals who met the requirement of four or more restraints within a 30 day period and could not, therefore, assess the efficacy of the practices required under this provision. 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. The Facility restraint policy includes language to do everything called for in C.7. The Monitoring Team had no opportunity to observe whether the policy would be	

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		implemented if needed (due to the minimal use of restraint, which is a positive finding). If an individual were to meet this criterion, the Monitoring Team would make a compliance determination at that time based on whether action taken followed the policy and was clinically adequate.	
	(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	RGSC did not have any restraint use that met these criteria during this review period. Deficiencies noted in section K of this report would suggest that RGSC would not meet the requirements of this element of this provision.	Not Rated

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	situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;		
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	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
	(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 self-assessment reported lack of compliance with this provision of the Settlement Agreement (SA). The Facility engaged in the following activities in conducting its self-assessment. The self-assessment process included a review of each of the four restraints to ensure the defined process of review by the Unit Team, the IMRT, and the PST occurred, and that the review was sufficient in scope to ascertain the circumstances under which such restraint was used and that the review took place within three business days of the start of each instance of restraint. This review was conducted by the Psychology Department. The RGSC self-assessment reported one of four (25%) did not meet these requirements resulting in a RGSC self-assessment rating of noncompliance. The chemical restraint of Individual #15 was not reviewed by the IDT until approximately three weeks after the restraint. In the last review this provision was rated as in substantial compliance as 100% of restraints review were adequately reviewed in accordance with the requirements of the SA. The RGSC had a sound process for restraint review that worked most of the time. The process begins with a FFAD done by the restraint monitor immediately after the restraint episode. The restraint episode is reviewed in the unit morning meeting the next business day with whatever information has been prepared by the time of the meeting. This often	Noncompliance

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		consists of verbal reports from staff. It is reviewed that same day by the IMRT, again often based on verbal reports from staff, either the Unit Director, Psychology Manager, or both. The restraint episode is kept on the agenda of both meetings until the restraint checklist, 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 IST for ISP revisions. Corrective Action Plans initiated at the IMRT meeting are put in place and tracked by the Incident Management Coordinator using a descriptive computer data base until closed. Documentation of these reviews are contained in IMRT meeting minutes and ordinarily contain 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 Interdisciplinary Team (IDT) the results are to be documented in an Individual Support Plan Addendum (ISPA) that becomes part of the permanent record.	

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

1. Comply with all requirements in RGSC SOPP 700-14 Use of Restraint and train/retrain staff as necessary to ensure proper implementation (Provisions C.1, C.2, C.3, C.4, C.5, C.6, and C.8).
2. Establish or modify internal administrative controls that are needed to ensure proper implementation of policy (Provisions C.1, C.2, C.3, C.4, C.5, C.6, and C.8).
3. Ensure all required staff training occurs. (Provision C.3)
4. Refine the self-assessment process to ensure each element of each provision is assessed, using quantitative data wherever possible (Provisions C.1, C.2, C.3, C.4, C.5, C.6, and C.8).

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 Self-Assessment and Action Plan 2/13/12 2. RGSC Section D Presentation Book 3. RGSC SOP ICFMR 200-08 Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/12) 4. RGSC SOP ICFMR 200-03 Incident Management (revision date 1/12) 5. RGSC SOP ICFDD 400-01 Injuries to Consumers (revision date 9/14/11) 6. DADS Policy 2.1 Protection From Harm - Abuse, Neglect, and Exploitation 5/11/11 7. DADS Policy 2.2 Incident Management 1/31/11 8. Poster used to inform staff, individuals, LARs, and visitors of A/N reporting responsibilities and related monitoring reports from 9/11 to 2/12 9. Criminal Background Check Due Diligence Report from DADS (9/11) 10. Training transcripts of Facility and Department of Family Protective Services (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 (2/12) 15. List of Peer caused injuries 9/1/11 to 2/13/12 16. Witnessed Injury Log 9/1/11 to 2/27/12 17. Discovered Injury Log 9/1/11 to 2/27/12 18. Unusual Incident Log 9/1/11 to 2/27/12 19. Serious Injury Log 9/1/11 to 2/27/12 20. Department of Family and Protective Services Investigative Reports and related documents 41004155, 40303361*, 40504997*, 40266170*, 40966063, 40269150, 40258053, 40982776, 41021026, and 40828701*. Cases marked with * were also investigated by the Office of Inspector General (OIG) 21. Facility investigations for non-serious discovered injuries for Individuals #15 (9/22/11), #3(1/3/12), #36 (11/6/11), #40 (11/27/11), #86 (2/20/12) and #101 (1/20/12) 22. Facility investigations for serious injuries and incidents UIRs 12-002, 005, 006, 007, and 008 23. Material used to educate guardians on abuse reporting (2/12) 24. Sample documentation of employee discipline taken post investigation 25. Incident Management Review (IMRT) minutes for 15 meetings from 11/1/11 to 1/31/12 26. Self-Advocates meeting minutes 9/20/11, 11/22/11, 12/20/11, and 1/24/12 27. Under Reporting Record Reviews for each month since September, 2011 28. UIR Audits for each month since September, 2011 29. Training transcripts for sample of 25 staff 30. Root Cause Analysis re: inconclusive findings (11/18/11)

	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. Juanita Newton, DFPS Investigator 8. Eli Perez, DFPS Investigator 9. Melissa Canales, Unified Records Coordinator **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 2/26/12 2. Settlement Agreement Performance Improvement Council (SA-PIC) 2/29/12 3. Shift change meeting Building 501 3/1/12 4. RGSC Advocates (Self Advocacy council) meeting of 2/28/12
	Facility Self-Assessment: The Facility's self-assessment process for Section D consisted almost entirely of 100% reviews by the Incident Management Coordinator of forms, reports, and other documentation designed to meet policy requirements. This did not appear to be an effective self-assessment process producing reasonably reliable results. Section D has 22 compliance components within its five provisions. The Facility self-assessment reported 19 (86%) to be in substantial compliance. The Monitoring Team determined 11 (50%) to be in compliance. The self-assessment process for Section D is in need of substantial improvement. The current self-assessment process also does not appear to be efficient. A 100% review of various documents and reports is more typically an administrative and supervisory activity to ensure that, for the most part, essential requirements have been met. A Facility self-assessment process should take a more critical look at component parts on a sample basis and would typically be done by personnel who are not directly responsible for the original work products. For example, in this instance the IMC appropriately reviews the work of her subordinates to ensure it complies with policy and, in instances where subjective judgment is involved, represents "our best effort." In a Facility self-assessment process someone from outside the IMC Office would review a sample of this work to validate the accuracy of the IMC self-assessment and/or identify areas in need of improvement. There are examples in Section D where it is appropriate for the IMC to conduct the Facility self-assessment. For example, the Human Rights Officer and the Unified Records Coordinator (who are not part of the IMC Office) audit some components of Section D compliance. In these cases it is appropriate that the Section D team leader (the IMC) conduct, on a sample basis, a review of the validity of the self-assessment data provided for inclusion in the Facility self-assessment. To summarize, a self–assessment process should include a methodology that ensures the accuracy of self-assessment data is independently validated by someone other than the staff responsible for the administrative activity which generated the performance and work activity data.

	Summary of Monitor's Assessment: The systems for abuse and neglect reporting and the incident management system at RGSC have regressed since the last compliance review. Seven components determined to be in substantial compliance at the last review are no longer in compliance and only one that was determined noncompliant last review has become compliant. The frequency of late reporting of allegations of abuse and neglect is alarmingly high. Late reporting also impacts the Facility's ability to identify and immediately remove alleged perpetrators from contact with Individuals. 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 the investigation review process determined it was appropriate for the staff person to return to his/her normal assignment. The content of some investigations, including those conducted by the Facility and by DFPS, are disconcerting and do not always seem to address obvious considerations in the conduct of a good and thorough investigation. On a positive note, the internal management and monitoring systems in place at RGSC were self-identifying many instances of noncompliance, especially in areas where clear data parameters exist such as the timeframes associated with reporting, with initiating investigations, and with completing investigations. A higher level of critical thinking is needed in the incident management review process. Processes, problems, and issues are routinely examined from only a cursory point of view. For example, the SA requires alleged perpetrators to be immediately removed from client contact. If an allegation is reported a day late an alleged perpetrator was not removed from direct contact with individuals immediately as required by the SA. The Facility did not recognize that one area of noncompliance can affect compliance in other areas in ways that increase risk to individuals. Issues were identified during this review that can substantially impact the thoroughness of DFPS investigations and the conclusions made with respect to an allegation. Oftentimes, several days lapse between a report of an allegation and the beginning of interviews of alleged perpetrators and collateral witnesses. From the sample selected by the Monitoring Team this time lapse was as much as nine days. This has impacted, in some cases, the credibility of testimonial evidence. The IMRT process is in place and functions as a review body, meets daily, and its minutes reflects review of injuries, incidents, and investigation reports. Nevertheless, the review process does not always ask the type of questions that reflect critical thinking. Certain injuries that on their face seem suspicious were not always probed with the level of scrutiny one would expect. Data recorded on trend reports has improved since the last review, most notably in the separate categorization of incidents investigated by DFPS.

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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 Rio Grande self-assessment reported substantial compliance with this provision of the SA. The Monitoring Team does not concur. A consistent failure to timely report allegations of abuse and neglect does not demonstrate a commitment on the part of the Facility to no tolerance or to an understanding that staff are required to report. In the last report this provision had been rated as in compliance with a comment that the Monitoring Team expected to see improvement in timely reporting. Data included in this report showed a much higher frequency of late reporting. The Facility reported it had engaged in the following activities to conduct its self-assessment: • Conducted a review of the facility's policies, procedures and practices to determine if the required commitment regarding zero tolerance of abuse and neglect of individuals was included. The Facility reported the results of its self-assessment as follows: • A review of facility policies, procedures and practices showed that the required commitment regarding zero tolerance of abuse and neglect of individuals was included. For any cases that resulted in a confirmation of Abuse, Neglect, or Exploitation, appropriate disciplinary action was taken for the employee, up to and including termination. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance because the required commitment regarding zero tolerance of abuse and neglect of individuals was included in the policy. 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 (1/12), 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 requirements of the Settlement Agreement. This policy, along with RGSC SOP ICFMR 200-03 Incident Management (1/12) and RGSC SOP ICFMR 400-01 Injuries to Consumers (9/11) provide the policy direction, if followed, needed to achieve compliance with this section of the SA. Compliance with this provision of the SA requires policy implementation that supports the requirements of the SA, most notably in timely reporting of abuse and neglect. The Facility identified nine instances where abuse or neglect was not reported within the timeframes established by policy. This included two allegations of physical abuse, six	Noncompliance

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		allegations of neglect, and one allegation of emotional/verbal abuse. While it is commendable that the Facility's internal review process identified these reporting issues, the frequency in which abuse and neglect was not reported timely according to policy is alarming. RGSC reported 49 allegations of abuse or neglect since the last review and from Facility reported data nine (18%) were not reported timely in accordance with facility policy. Furthermore, as reported in Provision D.2d, the level of facility response in terms of disciplinary or other performance actions for late reporting did not clearly demonstrate a lack of tolerance. Additionally the Monitoring Team review of a sample of 10 DFPS investigations revealed the following: • In four the date and time of the alleged incident was unknown. • In the remaining six allegations the date and time of the alleged incident was known and in five of the six (83%) the allegation was not reported within the one-hour timeframe. In four of these five allegations that were reported late the report did not occur until the next day (80%). Although the required policy is in place, it will be essential for the Facility to demonstrate significant improvement in implementation to achieve substantial compliance.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with	The Rio Grande self-assessment reported noncompliance with this component of this provision of the SA. The Monitoring Team concurs. The Facility reported it had engaged in the following activities to conduct its self-assessment: • Reviewed a random sample of two Unusual Incident investigation reports per month, since the last monitoring visit, to determine if incidents were reported to the Superintendent and/or DFPS within one hour of the incident occurring. • Revised (11/14/20) the UIR checklist to include whether or not the incident was reported within the one-hour timeframe. The Incident Management Coordinator (IMC) reviewed 100% of the UIR's to determine compliance.	Noncompliance

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	Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	• Continued competency check audits of staff that were initiated in February, 2011. The audit includes ten staff a month checking competency in identifying the proper procedure when reporting abuse, neglect, or exploitation. On the spot training was provided when staff answered any question incorrectly. • Conducted a review of preliminary and secondary investigation reports, when injuries met criteria per revised policy (implemented 12/2/11) The Facility reported the results of its self-assessment as follows: • UIR audit findings were as follows: 08/2011 – 90% and 100% compliance rating for an average of 95% 09/2011 – 100% and 100% compliance rating for an average of 100% 10/2011 – 95% and 94% compliance rating for an average of 94.5% 11/2011 – 94% and 94% compliance rating for an average of 94% 12/2011 – both audits at 100% compliance rating for an average of 100% Eight of the ten unusual incidents reviewed indicate that notification to DFPS was completed within one hour of suspected abuse, neglect or exploitation. One of the eight incidents reviewed was an internal investigation and was marked as not applicable. One out of the 10 audits reviewed noted that DFPS was not notified within the one hour period; however, the IMC verified with DFPS representatives that this case was reported previously and referred to them as an I and R (Information and Review). DFPS had the DFPS intake specialist re-enter this case which noted a much later time causing this case to appear to have been reported past the required timeframe. • Updated UIR Checklist was implemented in 11/2011. • Results of the abuse, neglect, or exploitation staff competency audits were as follows: 08/2011 - 90% compliance rating 09/2011 – 80% compliance rating 10/2011 - 80% compliance rating 11/2011 - 90% compliance rating On the spot training was provided to the individuals that did not answer correctly. Due to RGSC policy on keeping the anonymity of the reporter, RGSC is at times unable to address incidents that are reported after the one hour timeframe and unsure whether there were outcries made at a later date. • The RGSC Review Authority, a group of administrators established in policy who	

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		review DFPS reports and some UIRs after review by the IMC, reviewed a total of four non-serious discovered injuries that were submitted for review by the IDT. 2-injuries were reviewed for the month of November, 2011. 1-injury was reviewed for the month of December, 2011 0- injuries reviewed for the month of January, 2012. 1- injury was reviewed for the month of February, 2012. The Review Authority made recommendations in three of the four injuries reviewed; however, they did not suspect abuse, neglect or exploitation in any. The Facility determined that based on the findings from their self-assessment, this provision is not in substantial compliance because the process to review non-serious discovered injuries, to rule out abuse or neglect, had been in place for only a short period of time. The Monitoring Team concurs that this component of this provision is not in compliance but for a different reason. In a document request response, the Facility identified nine instances where abuse or neglect was not reported within the timeframes established by policy. This included two allegations of physical abuse, six allegations of neglect, and one allegation of emotional/verbal abuse. While it is commendable that the Facility's internal review process identified these reporting issues the frequency in which abuse and neglect is not reported timely according to policy is alarming. RGSC reported 49 allegations of abuse or neglect since the last review and from Facility reported data nine (18%) were not reported timely in accordance with facility policy. The Facility self-assessment process should have identified this as a significant compliance issue. As a check of staff knowledge with respect to abuse/neglect, during the review the Monitoring Team met with six direct care staff, three from the day shift and three from the afternoon shift. They were asked to complete the same five question abuse/neglect test they complete in training. Four answered all five questions correctly, one answered four questions correctly, and one answered three questions correctly. None of the six incorrectly answered the questions "to whom abuse/neglect is reported to", and "the one hour timeframe requirement". This was an overall aggregate score of 90% correct. The Facility has an ongoing system for on-the-spot competency testing to ensure staff retains the key requirements of abuse/neglect training. RGSC's Serious Injury Log provided data on serious injuries. From this report the Monitoring Team was able to determine the RGSC had five serious injuries between 9/1/11 and 12/31/11. Review of the investigation of these five serious injuries will comprise sample D.2.	

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		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 9/1/11 and preparation of the pre-visit document request. This sample included the following DFPS investigation reports: 41004155, 40303361*, 40504997*, 40266170*, 40966063, 40269150, 40258053, 40982776, 41021026, and 40828701*. Cases marked with * were also investigated by the Office of Inspector General (OIG) 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 five Facility investigations of serious injuries between 9/1/11 and 12/31/11. This included the following investigations: UIRs 12-002, 005, 006, 007, and 008. Based on a review of the 15 investigation reports included in both Sample D.1 and Sample D.2, nine (60%) 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 included UIR12-008, DFPS cases 41004155, 40266170, 40966063, 40258053, and 41021026. Four of the five DFPS allegations (80%) reported late were not reported to DFPS until the day after the incident occurred. Additional analysis of the 10 cases in Sample D.1 (DFPS investigations) revealed the following: • In four the date and time of the alleged incident was unknown. • In the remaining six allegations the date and time of the alleged incident was known and in five of the six (83%) the allegation was not reported within the one-hour timeframe. In four of these five allegations that were reported late the report did not occur until the next day (80%). 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 15 investigation reports included in Sample D.1 and Sample D.2, 15	

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		(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 non-serious 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 of non-serious discovered injuries. None (0%) of the six investigations were sufficient in scope and depth to rule out abuse or neglect. The process in place for review of non-serious injuries at the RGSC consisted of a preliminary review conducted by unit staff, usually completed by the Supervisor on duty and in charge at the time of discovery. This was referred to as the preliminary investigation. The preliminary investigation was forwarded to the Qualified Developmental Disabilities Professional (QDDP) for conducting a secondary investigation. The QDDP reviewed the preliminary investigation and gathered additional information regarding the circumstances associated with the injury. This information is reviewed with members of the IDT and they determine whether a reasonable probable cause can be determined, and, whether or not abuse and neglect can be ruled out. The QDDP also has an option of submitting the investigation to the Incident Management Office for additional investigation by a trained investigator. Some examples of insufficient investigations of discovered injuries include: • The investigation for an injury to Individual #15 (two injuries to the face) did not include a secondary investigation. The Individual reported (through interview) that "someone hit me." There is no information in the investigation report to document this was immediately reported to DFPS. Subsequent information shows it was not reported to DFPS until the next day. The only staff interviewed as part of the preliminary investigation was the staff who discovered the injury, not staff that worked with the individual prior to discovery of the injury. • The secondary investigation for an injury to Individual #36 (bruised eyelid) identified a probable cause as "self bump." The injury report describes a "linear bruise." If medical staff described an injury as a linear bruise the person conducting the secondary investigation should have noted the discrepancy in the injury description between linear bruise and self bump and investigated further. The investigation included detailed notes as to the Individual's activity and actions in the time period immediately preceding the discovery of the injury. None of the notes suggested the Individual bumped into anything. The secondary investigation noted that abuse or neglect is not suspected because of a self bump without offering any rationale as to how the alleged self bump occurred despite evidence that the Individual's documented activity did not describe self-injurious behavior and the injury report described a linear bruise, not a bump. Linear bruises should raise suspicion. This was an example of an investigation that should have been referred to the Incident Management Office for investigation by a trained investigator.	

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		• The secondary investigation for an injury to Individual #101 (large abrasion to the lower mid back) established a probable cause of "self-scratch." The possibility of abuse or neglect was ruled out because the Individual had "no change in behaviors or demeanor." Nothing in the secondary investigation report provides even a suggestion as to how someone could incur a large abrasion (rectangular in shape) to the lower middle back from a self-scratch. This was another example of an investigation that should have been referred to the Incident Management Office for investigation by a trained investigator. • Staff interviews and staff statements associated with the preliminary and secondary investigations typically focused 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 and scratches that would 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. • 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 have occurred as a result of staff neglect. • Certain discovered injuries, even though not rated serious, may warrant a more extensive investigation than the typical preliminary and secondary investigation process, including continued investigation by a trained investigator from the Incident Management Office and perhaps review of video surveillance tapes. This might be the case for an Individual who is frequently injured, where the location and/or type of the injury might automatically raise suspicion with respect to inappropriate interaction with staff, or peer-to-peer interaction, or where information in a preliminary/secondary investigation appears inconsistent or illogical as noted in the three examples described above. The documents showed no evidence that consideration of these issues led to additional investigation. The Facility needs to be much more critical in its review of non-serious discovered injuries to rule out abuse or neglect as a cause or contributing factor to a discovered injury. As noted, a probable cause was established in many cases without supporting evidence. When probable cause cannot be determined based on evidence, or when type or frequency of injury should raise concern, the Facility should at least be suspicious of and investigate the potential of abuse or of neglect in terms of the provision of care, adequate treatment and protections, including supervision of Individuals.	
	(b) Mechanisms to ensure that, when serious incidents such as	The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team does not concur. This component of this	Noncompliance

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	allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	provision was rated in substantial compliance at the last review. The pervasiveness of late reporting noted in Provision D.1 creates an environment where alleged perpetrators are not immediately identified and therefore cannot be immediately removed from client contact. The Facility reported it had engaged in the following activities to conduct its self-assessment: • The IMC reviewed 100% of facility investigation reports and DFPS final investigation reports to determine if named alleged perpetrators were immediately removed from direct contact with individuals pending the outcome of an investigation according to policy. The Facility reported the results of its self-assessment as follows: • 100% of investigation reports reviewed validated that where alleged perpetrators were named they were removed from direct contact pending the outcome of an investigation. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance due to alleged perpetrators being removed immediately from direct contact with individuals pending the outcome of an investigation according to policy. The Monitoring Team does not concur with this self-assessment because of the impact late reporting of allegations has on the Facility's ability to identify and remove alleged perpetrators in a timely manner. The Facility reported nine of 49 (18%) allegations were discovered to have been reported late. This was identified through the Facility's internal review process conducted by the IMC and the IMRT. The Monitoring Team, from its Sample D.1, determined a much higher rate of late reporting. Analysis of the 10 cases in Sample D.1 (DFPS investigations) revealed the following: • In four the date and time of the alleged incident was unknown. • In the remaining six allegations the date and time of the alleged incident was known and in five of the six (83%) the allegation was not reported within the one-hour timeframe. In four of these five allegations that were reported late the report did not occur until the next day (80%). Because of late reporting alleged perpetrators are not immediately removed from direct care responsibilities and as a result Individuals are placed at unnecessary risk. The Facility's self-assessment should have identified this problem. Review of the 10 investigations of abuse or neglect in Sample D.1 found there were not	

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		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 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 15 investigation files, it was documented that adequate additional action was taken to protect individuals (once a determination that a reportable incident occurred), where warranted, in each case. For example: nursing assessments were done and treatment rendered as appropriate, 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 Rio Grande self-assessment reported compliance with this component of this provision of the SA. The Monitoring Team concurs based on its assessment that the training was competency based and that 100% of employees completed the training but notes that while completion of required training courses is well documented the effectiveness of the training can be questioned. The high frequency of late reporting of allegations described in sections D.2.a and D.2.b of this report suggests a need for a critical review of the apparent disconnect between staff training and staff performance with respect to abuse/neglect recognition and reporting. The Facility reported it had engaged in the following activities to conduct its self-assessment: • The IMC reviewed the ABU0100 Course Delinquency List to determine if all RGSC employees had completed the training according to facility policy. The Facility reported the results of its self-assessment as follows: • The Delinquency List for ABU0100 dated 12/31/2011 revealed that 100% of RGSC employees successfully completed this training. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance because 100% of RGSC employees have completed this required training. RGSC SOP ICFMR 200-08 Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/12) requires that all staff complete class ABU0100 Abuse and Neglect pre-service and at least yearly, and that all staff complete class UNU0100 Unusual Incidents pre-service and at least yearly. Successful completion of these classes is sufficient to demonstrate compliance with the SA.	Substantial Compliance

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		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 confirmed 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. As an additional check of staff knowledge with respect to abuse/neglect, the Monitoring Team met with six direct care staff, three from the day shift and three from the afternoon shift. They were asked to complete the same five question Abuse/Neglect test they complete in training. Four answered all five questions correctly, one answered four questions correctly, and one answered three questions correctly. None of the six incorrectly answered the questions "to whom abuse/neglect is reported to", and the "one hour timeframe requirement". This was an overall aggregate score of 90% correct. The Facility has an ongoing system for "on-the-spot" competency testing to ensure staff retains the key requirements of abuse/neglect policy, including reporting. The Facility Human Rights Officer interviews 10 staff each month asking them standard questions on the Facility abuse/neglect/exploitation policy and reporting responsibilities. Responses were recorded and documented in a report submitted to the QA Director. These data were subsequently reviewed at a meeting of the SA-PIC. Any staff who responded to any question incorrectly was provided on the spot retraining. A training roster was maintained to document this training occurred. While considerable effort goes into training and testing staff on abuse and neglect policy and reporting requirements the frequency of late reporting, as noted in sections D.2.a and D.2.b of this report, is alarmingly high. The Facility may wish to conduct a root cause analysis to try and determine systemic actions that may be necessary to correct what appears to be a systemic problem.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to	The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA and the Monitoring Team concurs. The Facility reported it had engaged in the following activities to conduct its self-assessment:	Substantial Compliance

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	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 IMC reviewed a sample of nine staff hired between 11/16/2011 and 12/16/2011 to determine if the zero tolerance acknowledgements for abuse, neglect and exploitation, and the recognition of reporting obligations has been signed. The Facility reported the results of its self-assessment as follows: • IMC review of the nine staff hired between 11/16/2011 and 12/16/2011 found that all nine staff (100%) had signed the acknowledgement form. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance because 100% of staff hired have signed the acknowledgement form. Facility policy ICFMR 200-08 (1/12) 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. The Monitoring Team requested copies of the forms for the 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 may wish to expand its self-assessment methodology to include a random sample of all employees, not just recent hires. Form 1020 is an annual requirement and methodology needs to be established that validates long term employees have a current signed 1020 on file. Reviewing the information in the 1020 annually serves as an additional reminder to staff of reporting responsibilities. The Facility identified nine instances where abuse or neglect was not reported within the timeframes established by policy. This included two allegations of physical abuse, six allegations of neglect, and one allegation of emotional/verbal abuse. While it is commendable that the Facility's internal review process identified these reporting issues the frequency in which abuse and neglect is not reported timely according to policy is alarming. RGSC reported 49 allegations of abuse or neglect since the last review and nine (18%) were not reported timely in accordance with facility policy. The two staff who were untimely in reporting physical abuse received performance counseling and retraining on reporting requirements. The six staff who were untimely in reporting neglect received performance counseling. One of the six also was retrained on reporting requirements, and one also received	

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		"decision-making leave" which was described as one day of paid leave to allow the employee to give serious consideration to their continued suitability to remain an employee at the Facility. The one employee who was untimely in reporting emotional/verbal abuse was retrained on abuse/neglect reporting and unusual incidents. It is unclear to the Monitoring Team that appropriate personnel action in response to a mandatory reporter's failure to report abuse or neglect occurred. At a cursory level this does not seem to be the case. The Monitoring Team did not conduct an extensive review of personnel files which would have been necessary to assess this subject. The Facility should review its practices in this regard with DADS human resource specialists to ensure its administrative action is consistent with the SA requirement in Provision D.1 and demonstrates "commitment that the Facility shall not tolerate abuse or neglect of individuals." .	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	The Rio Grande self-assessment reported lack of compliance with this component of this provision of the SA and the Monitoring Team concurs. The Facility reported it had engaged in the following activities to conduct its self-assessment: • Reviewed 100% of ISP documentation for the months of September, 2011(5), October, 2011(7), November, 2011 (9), and December, 2011 (4) to ensure that individuals and/or LAR were provided educational material at the ISP meeting regarding how to identify and report unusual incidents and allegations of abuse, neglect, and exploitation. The Facility reported the results of its self-assessment as follows: • The review of the 100% of ISP audited are as follows: o The September, 2011 audit revealed that 80% of the individuals and/or LAR were provided educational material regarding how to identify and report unusual incidents and allegations of abuse, neglect, and exploitation. o The October, 2011, audit revealed that 90% of the ISP audits noted that the QDDP provided the ANE pamphlet to the individual/ LAR's who attended the ISP. o The November, 2011 audit revealed that 100% of the ISP audits noted that the QDDP provided the ANE pamphlet to the Individual/LAR's who attended the ISP. o The December, 2011 audit revealed that 100% of the ISP audits noted that	Noncompliance

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		the QDDP provided the ANE pamphlet to the Individual/LAR's who attended the ISP. The Facility determined that based on the findings from their self-assessment, this provision is not in substantial compliance because there was no documentation to demonstrate this information had been shared at the annual meeting when the family/LAR are not in attendance. In its review of ISP documents the Monitoring Team did not detect any documentation that would contradict the Facility's self-assessment. Facility policy (ICFMR 200-08) requires maintenance of 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. Policy requires this resource guide be provided to individuals at admission to the Facility and annually to coincide with ISP preparation and at the ISP meeting. These materials 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 IDT is required to meet with each individual prior to their ISP meeting to review this information. The IDT is required to review this information at the ISP meeting with the individual and his/her guardian or LRA. The Facility had modified the ISP Observation Monitoring Tool to record whether or not the ISP meeting covered these topics. Monitoring Team members attended the one ISP annual planning meeting held the week of the review; there was no discussion during the meeting of abuse, neglect or other reportable incidents. The individual's LARs were not able to attend the meeting, and the Monitoring Team did not determine whether materials had been provided to them at another time. During the self-advocate meeting held during the week of the review, the Human Rights Officer (HRO) asked individuals if they knew what to do if someone hurt them. 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. One allegation of abuse had been identified as being reported by an individual's family member. Nine allegations of abuse or neglect had been reported by an Individual (six over a two day span). All ten had been investigated by DFPS and resulted in a finding of unconfirmed.	

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	(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 Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team concurs. The Facility reported it had engaged in the following activities to conduct its self-assessment: • The Human Rights Officer (HRO) conducted a routine walk through of all living units and day programming areas on a monthly basis as part of her assigned duties. During this walk through, she checks to ensure that a "Rights Poster" is displayed. There should be at least one poster in each living unit and one poster in each day programming area. If a poster is missing, a supply of posters is maintained in the Superintendent's office and they are immediately replaced. The Facility reported the results of its self-assessment as follows: • Since the last review the walkthrough results are as follows: o 08/19/2011 - Spanish poster needed to be replaced (#502 training room) work order was submitted on 08/19/2011 and it was replaced on 08/22/2011. o 09/20/2011 - no concerns noted. o 11/17/2011 - no concerns noted. o 12/27/2011 - no concerns noted. o 01/27/2011- no concerns noted. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance because the "Rights Posters" are displayed in each living unit and day program area. 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 Spanish. This is especially important at the RGSC since Spanish is the preferred language of many Individuals and their family.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team concurs. The Facility reported it had engaged in the following activities to conduct its self-assessment: • The IMC reviewed 100% of DFPS cases, 50 of 50 from 8/3/11 to 1/2/12, to determine that appropriate cases were referred to local law enforcement and OIG on	Substantial Compliance

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		a consistent and regular basis. The Facility reported the results of its self-assessment as follows: • All DFPS allegations reviewed, 50 of 50 from 8/3/11 to 1/2/12, were referred to local law enforcement and OIG on a consistent and regular basis, as appropriate. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance because 100% of DFPS were reported to law enforcement and OIG on a consistent and regular basis. In reviewing Sample D.1 (DFPS cases) the Monitoring Team determined two of 10 (20%) did not have law enforcement notification documented in the DFPS case report. These were: 1. Case 40966063 (unconfirmed neglect) 2. Case 40258053 (confirmed neglect) The Monitoring Team is not of the opinion these two cases merited specific law enforcement referral. All allegations of physical abuse were appropriately referred to law enforcement. The Facility self-assessment reported all DFPS cases (including those that were not physical abuse) were reported to law enforcement. The Monitoring Team found some were not (but did not need to be). The Facility should ensure that self-assessment review activity validates accuracy of data provided and clearly describes what the data represent.	
	(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 Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team concurs. The Facility reported it had engaged in the following activities to conduct its self-assessment: • The Facility reviewed 100% of all facility investigation reports and DFPS final investigation reports, 61 of 61 from 8/3/11 to 1/2/12. This review was conducted to determine if retaliation against individuals, their families and LAR's, as well as employees who reported allegations of abuse/neglect/exploitation in good faith had occurred. The Facility reported the results of its self-assessment as follows: • The review of all RGSC and DFPS investigations revealed there were no instances where staff felt they had been retaliated against for reporting an allegation in good faith. The IMC contacted the Superintendent to cross reference findings and note whether she had received any reports or retaliation. The Superintendent stated she	Substantial Compliance

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		had not received any incidents of retaliation. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance because RGSC SOP ICFMR 200-08 Protection from Harm – Abuse, Neglect, and Exploitation (1/12) included specific requirements in section IX associated with this component of the SA. 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. During this review the Monitoring Team interviewed two DFPS Investigators. Neither was aware of specific retaliation directed towards a reporter of abuse/neglect or other staff interviewed as witnesses. Both, however, indicated that occasionally, in the context of an interview, some staff expressed concern about retaliation. The DFPS investigators did not feel the level of concern expressed in these situations was significant enough to include in the investigation report, or report informally to Facility administration. The Facility may wish to include discussion of this topic in their periodic administrative meetings with DFPS and OIG.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The Rio Grande self-assessment reported compliance with this component of this provision of the SA. The Monitoring Team does not concur. The Facility reported it had engaged in the following activities to conduct its self-assessment: • The Facility conducted a review of monthly audits, two per month since the last monitoring visit, completed by Health Information Management (HIM) to determine if underreporting is noted. This audit consisted of a review of all CWS progress notes, nursing assessment and quarterly reviews spanning the previous 90 days. The Facility reported the results of its self-assessment as follows: • 8/11 audits- no evidence of under reporting noted. 9/11 audits - no evidence of under reporting noted. 10/11 audits - no evidence of under reporting noted.	Noncompliance

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		11/11 audits - no evidence of under reporting noted. 12/11 audits - no evidence of under reporting noted. Findings are reported monthly to SA-PIC. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance because monthly audits were being implemented and no instances of underreporting were noted. One element of this component of this provision is to identify significant injuries that should have been reported for investigation and validate they had. The process in place at RGSC accomplishes this. An additional purpose of a semi-annual audit of injuries is to ensure that patterns of non-serious injuries that might raise suspicion of abuse or neglect are identified and subject to investigation. This requires review and analysis of Facility data. Such an audit might analyze six-months of injury data and identify individuals with large numbers of non-serious injuries that could raise suspicion, such as falls, or peer caused injuries. Data analysis could determine if a significant number of these injuries occur when a certain staff person is on duty, or they occur at a certain location, or any other variable determined to be potentially significant. This data analysis (i.e. the semi-annual audit) could determine that a formal investigation should be initiated. While the RGSC is to be commended for the audit system of individual record review it has put in place, the Facility needs to initiate audit/review activity that is broader in scope.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be	The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA and the Monitoring Team concurs.	Substantial Compliance

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	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 Facility reported it had engaged in the following activities to conduct its self-assessment: • Reviewed the training transcripts of the IMC, Facility Investigators, and Campus Administrators to ensure that required training has been completed. The Facility reported the results of its self-assessment as follows: • Based upon the review of the training transcripts and certificates of the IMC, both Facility Investigators, and four of four currently employed Campus Coordinators, all had completed Persons with Mental Retardation (MEN0100), Abuse, Neglect & Exploitation (ABU0100), and Unusual Incidents (UNU0100). Also, the IMC, the two Facility Investigators, and four of four Campus Administrators had completed the course Conducting Serious Incident Investigations (INV0100). The IMC and the two Facility Investigators had also completed the Comprehensive Investigator Training (CIT0100) course. One of the two facility investigators was scheduled to take the Root Cause Analysis training in Austin, Texas on 2/24/12 and will be participating in a Root Cause Analysis conducted at RGSC in 02/12. One of the four Campus Coordinators will also be attending the Root Cause Analysis training on 2/24/12, in Austin, Texas. The Facility determined that based on the findings from their self-assessment, this component of this provision is in substantial compliance because all investigators have completed all of the training requirements. 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 and 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 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	

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		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 usually thorough and comprehensive and case reports were usually well written, the Monitoring Team is of the opinion that this training is competency-based. 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 investigation training. Three investigators also completed the MH/MR overview. These five investigators conducted DFPS investigations reviewed by the Monitoring Team. Two investigators completed training in 2008. DFPS does not appear to include within its training program classes (refresher) to ensure investigators remain proficient in the	

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		basic principles of conducting investigations. For example, no training classes noted on the transcripts for the investigators who had training in 2008 were titled in a way that suggested they were "refresher" training. The Monitoring Team is concerned as to whether DFPS has a process to provide refresher training at pre-determined intervals (this does not appear to be the case from reviewing training transcripts) or some other mechanism to validate, at pre-determined intervals, the continued competency of investigators. A similar concern is expressed with regard to Facility Investigators whose comprehensive investigator training may have occurred several years ago. 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 four staff (campus coordinators) identified as investigators. The Monitoring Team reviewed their training records. All four (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 Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team concurs. The Facility reported it had engaged in the following activities to conduct its self-assessment: • The IMC conducted a 100% review, 61 of 61 from 8/3/11 to 1/2/12, of facility investigation reports and DFPS final investigation report, to determine if the facility staff cooperated with DFPS in conducting investigation of abuse and neglect as required by facility policy. The Facility reported the results of its self-assessment as follows: • All cases reviewed revealed that Facility staff cooperated with DFPS in conducting investigations. The Facility determined that based on the findings from their self-assessment, this component of this provision is in substantial compliance because review showed that facility staff cooperated with DFPS in conducting investigations. Review of the investigation files in Sample D.1 and Sample D.2 showed that in all 15	Substantial Compliance

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		(100%) investigations, Facility staff cooperated with DFPS and RGSC investigators. In addition, the Monitoring Team interviewed two DFPS Investigators. 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 Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA and the Monitoring Team concurs. The Facility reported it had engaged in the following activities to conduct its self-assessment: • The IMC conducted a 100% review of DFPS final investigation report, 50 of 50 from 8/3/11 to 1/2/12, to determine if investigations were coordinated with any investigations completed by law enforcement agencies so as not to interfere with investigations. As of 06/01/2010, DFPS began notification of allegations of ANE to OIG as deemed appropriate by DFPS and local law enforcement. The Memorandum of Understanding (MOU) dated 06/2010 delineates the roles and responsibilities of the parties relating to the investigation of a report of alleged abuse, neglect, or exploitation in the State Supported Living Centers and the ICF/DD component of the Rio Grande State Center. The MOU also provides for the coordination of investigations between OIG and local law enforcement. Meetings are scheduled with DFPS and OIG as concerns are identified. The last meeting was held with the DFPS local supervisor and DFPS regional supervisor, Superintendent, Quality Management Director, and ICF-DD Director. The concern identified/discussed was the increase in inconclusive findings. The Facility reported the results of its self-assessment as follows: • A review of the 100% of facility and DFPS investigations reveal that there is no evidence of interference by one agency or another. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance because no investigation showed evidence of interference by either agency. The Monitoring Team review of investigations did not detect any evidence of interference by one agency or the other.	Substantial Compliance

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	(d) Provide for the safeguarding of evidence.	The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team does not concur. This component of this provision had previously been rated in compliance. Unaddressed issues related to testimonial evidence preclude a continued rating of compliance. The Facility reported it had engaged in the following activities to conduct its self-assessment: • The IMC reviewed 100% of facility investigation reports and DFPS final investigation reports, 61 of 61 from 8/3/11 to 1/2/12, to determine if evidence had been collected, stored, and secured according to facility policy. The Facility reported the results of its self-assessment as follows: • The IMC review of all investigation reports indicated that evidence was being handled according to policy. A review of evidence collected indicates it was all testimonial and documentary, and that no physical evidence had been collected. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance because review showed that evidence was being handled according to policy. While on site, the Monitoring Team observed the area the Facility uses for safeguarding physical evidence. Based on a review of the investigations completed by DFPS (Sample D.1) and the Facility (Sample D.2) any physical evidence that needed to be safeguarded was. Additionally, when interviewed by the Monitoring Team neither DFPS Investigator reported any issues with the protection of physical evidence. The Monitoring Team has a concern with the protection of testimonial evidence. As noted in D.3.e of this report it is not uncommon for the interview process of alleged perpetrators and collateral witnesses to begin until several days after an allegation has been reported to DFPS. The Facility did not appear to have any effective mechanism to prevent the potential contamination of testimonial evidence. This is important because in DFPS cases reviewed by the Monitoring Team conclusions are based almost entirely on testimonial evidence. DFPS investigators interviewed by the Monitoring Team expressed some concern that too often the testimonial evidence collected through interview was so similar that it raised a suspicion of collaboration. One investigator indicated that because of this	Substantial Compliance

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		interviews often are not very helpful in determining case facts leaving the investigator with little alternative other than to report an "inconclusive" finding. The RGSC was so concerned about the number of DFPS investigations returned with inconclusive findings it convened a special meeting with DFPS to express and discuss this concern. The Monitoring Team does not believe the RGSC has taken adequate steps to provide for the safeguarding of testimonial evidence and this has impacted DFPS's ability to reach reasonable conclusions in their investigations of allegations of abuse and neglect. RGSC, along with DFPS, need to establish a methodology that can reasonably protect testimonial evidence. Although the Monitoring Team raises this significant concern, based on criteria used in prior reviews of this and other facilities, it finds that safeguarding of physical evidence is adequate to result in a finding of substantial compliance with this provision.	
	(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 Rio Grande self-assessment reported non- compliance with this component of this provision of the SA. The Monitoring Team concurs but for a different reason than that presented in the self-assessment. The Facility self-assessment determined noncompliance based on the short duration a new review form had been in place. The Facility self-assessment process did not include a critical review of compliance related issues associated with DFPS reportable serious incidents (allegations of abuse and neglect). The Monitoring Team identified several issues related to this. The RGSC self-assessment focused on the completion of a UIR checklist. The RGSC self-assessment should have identified many of the same issues noted by the Monitoring Team which would have resulted in a self-assessment determination of noncompliance based on substantive factual information. The Facility reported it had engaged in the following activities to conduct its self-assessment: • Revised the Unusual Incident Investigation Review Checklist on 11/14/11, to include the question of whether or not the investigation was initiated and completed within the allotted timeframes. Three Unusual Incident reports were reviewed utilizing this form in the month of November. All proceeding UIR's will be reviewed utilizing this form. The Facility reported the results of its self-assessment as follows: • Three of three incidents reviewed for the month of November, using the revised checklist, indicated that investigations were being processed according to timeframes in accordance with the Settlement Agreement.	Noncompliance

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		For the month of 12/11, seven of eight Unusual Incidents reviewed were completed within the ten day timeframe. (87.5% compliance) The Facility determined that based on the findings from their self-assessment, this provision is not in substantial compliance due to the short duration that this recently revised form has been in use. 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> DFPS had modified its report format to more clearly summarize investigatory activity undertaken by DFPS within 24 hours of an allegation being reported. Typical activity reported in case reports included telephone contact with the Facility's Incident Management Coordinator or Campus Coordinator to ensure the individual who is the subject of the report is safe (and if injured has received appropriate medical care) , that any known APs were placed in NDC status, the identification of any collateral witnesses, that the Facility has (or is) gathering all relevant documentation, that any physical evidence is secure, a determination if there is likely video surveillance evidence to review, and the development and review of a preliminary investigation plan. All ten (100%) cases in Sample D.1 documented these type of activities took place within the first 24 hours. Although all cases had documentation of substantive investigatory activity, the Monitoring Team would like to point out, for information and consideration by the Facility, an issue that could affect the ability to gather all useful information that may be useful in arriving at an accurate conclusion. An additional measure to assess whether or not an investigation commenced within 24 hours of an incident being reported is to assess the date/time of the first substantive interview, which most typically would be of the reporter, a staff person, or an individual who can share information that is believed to be reliable and relevant to the investigation. Only one (10%) of 10 cases in Sample D.1 included interviews with collateral witnesses or the alleged perpetrator beginning within 24 hours of the report to DFPS. This was case 40258053. Onsite interviews of collateral witnesses' and APs often did not begin until 5-10 days after the report of an incident. For example, the first interview of an alleged perpetrator or collateral witness did not occur until: • Case 40269150 - 6 days after commencement of the investigation. • Case 40828701 - 9 days after commencement of the investigation.	

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		• Case 40266170 - 6 days after commencement of the investigation. • Case 40966063 - 5 days after commencement of the investigation. • Case 41021026 - 7 days after commencement of the investigation. An example of how this delay in beginning the interview process may affect an investigation is described in Provision D.3.f for case 40269150. A significant time lapse between when an incident occurred and when alleged perpetrators and collateral witnesses are interviewed can potentially affect the integrity and efficacy of an investigation. This can occur because of diminished memory recall or collaboration among witnesses that can affect the truthfulness of testimonial evidence. This is important because in DFPS cases reviewed by the Monitoring Team conclusions are based almost entirely on testimonial evidence. An example of how this may affect an investigation is described in Provision D.3.f for case 40269150. When the findings and conclusion of an investigation can be expected to rely primarily on testimonial evidence, it is critical that such evidence be gathered early in the investigation. Both DFPS investigators interviewed by the Monitoring Team expressed some concern that too often the testimonial evidence collected through interview was so similar that it raised a suspicion of collaboration. One investigator indicated that because of this interviews often are not very helpful in determining case facts leaving the investigator with little alternative other than report an "inconclusive" finding. An example of this possibly occurring is described in Provision D.3.f for case 40269150. The RGSC was so concerned about the number of DFPS investigations returned with inconclusive findings the Facility convened a special meeting with DFPS to express and discuss this concern. Additionally, it appears that collateral witnesses are ordinarily not required to write witness statements until the time of interview. As noted previously, the Monitoring Team is concerned this time lapse can compromise the usefulness of testimonial evidence, and witness statements, either because of memory recall or inappropriate collaboration between an alleged perpetrator (AP) and/or collateral witnesses. This is somewhat less of a concern in instances where the events surrounding an incident are recorded by the video surveillance cameras, although this surveillance does not record audio. Efforts should be made within the first 24 hours to determine the importance to the investigatory process of face-to-face interviews with collateral witnesses and APs and to schedule those deemed high priority at the earliest possible time. The Monitoring Team does not believe DFPS or the RGSC has taken adequate steps to	

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		provide for the safeguarding of testimonial evidence and this has impacted DFPS's ability to reach reasonable conclusions in their investigations of allegations of abuse and neglect. RGSC, along with DFPS, need to establish a methodology that can reasonably protect testimonial evidence. Eight of the 10 (80%) investigations were completed within 10 calendar days of the incident. The documentation files prepared by the Facility and presented to the Monitoring Team for review did not contain a written Extension Request Form noting supervisor approval for the two investigations taking longer than 10 days to complete. However, it was unclear whether these two investigations actually were or were not completed within 10 days, as the investigators entered different dates of investigator signatures than the reports stated as completion dates. All 15 (100%) investigations in Sample D.1 and D.2 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 in Provision D.3.f of the Settlement Agreement. In one of the investigations reviewed, the DFPS report included concerns and recommendations for corrective action that were appropriate to the circumstances of the investigation. In three investigations no concerns or recommendations were included in the investigation report but probably should have been. Discussion of this issue is included in section D.2.f of this report. 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 in Provision D.3.f of this report. <u>Facility Investigations</u> The following summarizes the results of the review of five Facility investigations: Documentation contained in the UIR shows that all five investigations (100%) commenced within 24 hours or sooner, if necessary, of the incident being reported. Documentation contained in the UIR shows that four investigations (80%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. UIR 12-005 was not. All five (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed in Section D.3.f of this report.	

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		In all five of the investigations reviewed, recommendations for corrective action are included. In all five 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 Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team does not concur. This component of this provision had been rated as in compliance. Issues that emerged in the review of several investigation reports preclude a rating of continued compliance. The Facility reported it had engaged in the following activities to conduct its self-assessment: • The IMC reviewed 100% of facility investigation reports and DFPS final investigation reports, 61 of 61 from 8/3/11 to 1/2/12, to determine if the content of the reports show a clear basis for its conclusions. The Facility reported the results of its self-assessment as follows: • All investigations reviewed indicated that facility investigation reports and DFPS final investigation reports showed a clear basis for its conclusions. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance because reports show that there was a clear basis for report conclusions. The contents of the investigation reports reviewed did not always provide a clear basis for their conclusions, as noted below. The reports utilized a standardized format that set 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.	Noncompliance

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		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. DFPS Investigations The following summarizes the results of the review of DFPS investigations: In seven of 10 (70%) investigations reviewed the contents of the investigation report were sufficient to provide a clear basis for its conclusion. Those that did not included cases 40303361, 40269150, and 40504997. Each is discussed separately: • Case 40303361 – This is an allegation of neglect and physical abuse with an inconclusive finding. The alleged victim was on 1:1 level of supervision (LOS). The investigation report does not indicate if everyone assigned 1:1 LOS for a specific time period prior to the report of the allegation was interviewed. The report indicates that credible evidence shows that it is "unknown if (the alleged victim) was being supervised at the time of the alleged incident as required." A thorough interview process should have been able to validate this one way or the other. The investigation notes no concerns or recommendations. If the Facility was unable to produce documentation (e.g. 1:1 assignment sheets – the evidence list does not include such a document) that would be a concern. If staff interviewed were unable to describe their activity while engaged in 1:1 supervision that would be a concern. • Case 40269150 - This is an allegation of neglect with an inconclusive finding. The alleged victim was on 1:1 level of supervision (LOS). The evidence list includes a document that shows which staff were assigned 1:1 supervision for a seven day period prior to the discovery of a suspicious injury that was reported to DFPS. This list contains very specific time intervals with staff signatures validating the assignment. The investigation report does not indicate if everyone assigned 1:1 LOS for a specific time period prior to the report of the allegation was interviewed. The Monitoring Team asked the Facility IMC to cross-reference the staff names on the 1:1 assignment sheet with the staff names noted in the investigation report as being interviewed by DFPS. Fourteen staff that were assigned 1:1 supervision with the alleged victim were not interviewed by DFPS. Interviews that did occur did not start until six days after the report of the incident. Twelve Direct Care Professionals who worked with the individual were interviewed over a four-day period beginning six days after the injury and allegation of neglect was reported to DFPS. Their account of events was very similar with each interviewee reporting nearly identical statements such as "did not see any staff or clients cause an injury," "Individual did not have any behavioral episodes," "Individual did not mention being in pain," and in summary "I	

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		have no knowledge as to how the Individual sustained the injuries." The similarity of responses could suggest that the interviews associated with this investigation consisted of a set of rote questions and did not probe in depth to ask follow-up questions like who the interviewee took over 1:1 responsibility from or specifically what the staff person and the individual were doing during the 1:1 in general, and that might have led to injury. Interview questions like this, particularly if interviews are conducted using a reverse timeline of 1:1 assignments can lead to inconsistencies that may direct the investigation to a determinate finding. This investigation resulted in an inconclusive finding. The report also states "staff should have remained with arm's length for safety and protection 24 hours a day." The investigation was apparently unable to obtain sufficient information through interviews to determine which staff, if any, were not adhering to 1:1 LOS requirements, or, if they were, why they had no knowledge of how the injury occurred. The evidence list in the investigation did not include review of video evidence or reference to its unavailability. The investigation notes no concerns or recommendations. If video evidence was not available that should be a concern. If the summation of all staff interviews was "no one saw or heard anything (despite 1:1 LOS)" that should be a concern. If staff interviewed were unable to describe their activity while engaged in 1:1 supervision that should be a concern. • Case 40504997 – This is an allegation of physical abuse with an unconfirmed finding. The investigation report includes a reiteration of staff statements obtained beginning three days after the report of the allegation of physical abuse. The report identified this as from a written statement; it was not clear that any of these witnesses were interviewed. The basis for the unconfirmed finding rests exclusively on a doctor's opinion that "I can safely rule out abuse from staff." The doctor also noted the injury was not consistent with activity related to a recent seizure and was likely self-induced. The report identified this as from a written statement; it was not clear the doctor was interviewed to provide more detailed information to support his hypothesis that "I can safely rule out abuse from staff." An obvious consideration would be that an injury to the area of the eye that is believed to be self-induced could likely also have been caused by someone else striking the individual; and, what specifically about the injury would cause the doctor to determine the cause as one versus the other. 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 9 (90%), the name(s) of all witnesses; o In 9 (90%), the name(s) of all alleged victims and perpetrators; o In 9 (90%), the names of all persons interviewed during the investigation; o In 9 (90%), for each person interviewed, a summary of topics discussed,	

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		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 one of five (20%) investigations reviewed the contents of the investigation report were sufficient to provide a clear basis for its conclusion. Those that did not included UIRs 12-002, 005, 006, and 007. These conclusions were made after reviewing the documentation files prepared by the Facility for the Monitoring Team. Each is discussed separately: • 002 – This serious injury was reported to DFPS after RGSC investigation. The Facility investigation report did not include any documentation as to how the determination that the serious injury may have resulted from abuse/neglect was made, who made it, or when it was made. • 005 – No information was provided to validate a preliminary and secondary investigation occurred, or alternatively that the facility investigation included subject matter ordinarily obtained from these two sources. As a result the investigation of this serious injury did not contain an explicit statement, and rationale, ruling out abuse or neglect as a cause or contributing factor. • 006 – The injury report notes the injury was witnessed. The investigation did not identify any witnesses or include any validation that witnesses were interviewed. The investigation of this serious injury did not contain an explicit statement, and rationale, ruling out abuse or neglect as a cause or contributing factor. • 007 – The injury report notes the injury was not witnessed when clearly it was. The investigation included witness statements and the narrative in the investigation report supports the fact the injury was witnessed. The investigation of this serious injury did not contain an explicit statement, and rationale, ruling out abuse or neglect as a cause or contributing factor. In these four investigations the contents of the investigation report were insufficient to provide a clear basis for its conclusion. The report utilized a standardized format that set forth explicitly and separately	

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		▪ In five (100%), each serious incident or allegations of wrongdoing; ▪ In four (80%), the name(s) of all witnesses; ▪ In five (100%), the name(s) of all alleged victims and perpetrators; ▪ In four (80%), the names of all persons interviewed during the investigation; ▪ In four (80%), 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 five (100%), all documents reviewed during the investigation; ▪ In five (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 five (100%), the investigator's findings; and ▪ In one (20%), 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 review was 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 did not appear to the Monitoring Team that this review looks at all available information with a critical eye as evidenced by the issues identified by the Monitoring Team.	
	(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 Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team does not concur. This component of this provision had previously been rated in compliance. Issues reported in D.3.f above demonstrate that the scope of review required in this component was insufficient. The Facility reported it had engaged in the following activities to conduct its self-assessment: • The IMC reviewed 100% of facility investigation reports and DFPS final investigation reports, 61 of 61 from 8/3/11 to 1/2/12, to determine if reports were thorough, complete, accurate and coherent. The Facility reported the results of its self-assessment as follows: • All reports reviewed indicated that facility investigation reports and DFPS final	Noncompliance

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		investigation reports were reviewed by a supervisor and found to be thorough, complete, accurate and coherent. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance because reviews indicated that facility investigation reports and DFPS final investigation reports were reviewed by a supervisor and found to be thorough, complete, accurate and coherent. 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. A review of Sample D.1 and D.2 validated that reports are reviewed by staff supervising investigations; however; as reported in section D.3.f above, this review did not ensure that the investigations were thorough and complete and that reports were accurate, complete and coherent. These reviews also did not identify deficiencies or areas of an investigation requiring further inquiry such that deficiencies could be addressed promptly.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team does not concur. This component of this provision had previously been rated in compliance. Issues reported in D.3.f and D.3.g above demonstrate that the scope of review that results in the review report required in this component was insufficient. The Facility reported it had engaged in the following activities to conduct its self-assessment: • Reviewed 100% of facility investigation reports and DFPS final investigation reports, 61 of 61 from 8/3/11to 1/2/12, to determine that RGSC prepared a written report for each unusual incident, subject to subparagraph G. The Facility reported the results of its self-assessment as follows: • All reports reviewed indicated that a written report was prepared for each unusual	Noncompliance

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		incident, subject of subparagraph G. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance because reviews indicate that a written report was prepared for each unusual incident. The Facility is correct in reporting a written report is prepared. Compliance with this component of this provision also requires that subject matter in Provision D.2.g be addressed in investigation reports. As reported in Provision D.2.g this was not always the case. 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. As reported in D.2.g these reviews do not appear to include sufficient substance and depth to identify issues with investigatory methodology or investigation conclusions, or to ensure all required components of the report document are completed.	
	(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 Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team does not concur. This component of this provision had previously been rated in compliance. The Facility did not have a system or any defined methodology to determine if the outcomes of disciplinary or programmatic actions corrected a situation and/or prevented recurrence. The Facility reported it had engaged in the following activities to conduct its self-assessment: • Campus Coordinators conducted a random sample of facility investigation reports and DFPS final investigation report, one per week for a total of four per month for the period of 8/1/11 to 12/30/11 to determine if recommendations had been tracked and there was documentation of corresponding outcomes. The Facility reported the results of its self-assessment as follows: • Results of the UIR Recommendation Audits are as follows: 8/11, 2 of 5 audits - 40%. Of the audits reviewed, 2 were found with all recommendations completed. The other 3 audits generated Corrective Action Plans (CAPS) which were tracked, monitored and closed by our Settlement Agreement Clerk.	Noncompliance

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		For the months of 09/2011 and 10/2011 all four audits were noted to be at 100%. All recommendations were completed. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance due to the tracking system currently in place and the results of the audits that have been completed. 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. This system was deficient in meeting an important element of this component of the SA: assessing if the outcomes of disciplinary or programmatic actions corrected a situation and/or prevented recurrence. For example, staff training was often a recommendation from IMRT reviews. The Monitoring Team was unable to determine if the Facility engaged in any administrative review activity to determine if training and retraining (related to specific subject matters) had resulted in a change (decrease or increase) in the problem(s) the training directed by the IMRT was intended to address.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA and the Monitoring Team concurs. The Facility reported it had engaged in the following activities to conduct its self-assessment: • Reviewed procedure for the storage of investigation files to ensure that investigators/appropriate personnel have access to every investigation. The Facility reported the results of its self-assessment as follows: • Review of storage procedure revealed that printed copies were filed in an orderly and up to date manner in the investigation files. The Facility determined that based on the findings from their self-assessment, this is in substantial compliance because storage procedure revealed that the investigations were up to date and filed in a way that the investigators/appropriate personnel have access to every investigation.	Substantial Compliance

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		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 easily 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 Rio Grande self-assessment reported compliance with this provision of the SA and the Monitoring Team concurs. The Facility reported it had engaged in the following activities to conduct its self-assessment: • Reviewed database to determine if the facility has a system in place that allows tracking and trending of unusual incidents and investigations. The Facility reported the results of its self-assessment as follows: • Results of the database review indicated that tracking, trending and analysis of the data was not yet being used to its full potential. Changes to the reports were initiated to track the data over time, allowing the review team to see 12 months of data when conducting their CATW[2] analysis. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance due to the addition of the rolling 12 month data now being used to analyze the current data. The Monitoring Team review of trend reports validated inclusion of data required under this provision. Section E of this report contains some suggestions as to how data collection may be improved and used.	Substantial Compliance
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or	The Rio Grande self-assessment reported substantial compliance with this provision of the SA and the Monitoring Team concurs. The Facility reported it had engaged in the following activities to conduct its self-assessment: • Initial and annual checks with the Employee Misconduct Registry, the Nurse Aide Registry, the Client Abuse and Neglect Reporting System and the Federal Bureau of Investigation for employee fingerprints are conducted for 100% of applicants, employees and volunteers.	Substantial Compliance

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	volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	The Facility reported the results of its self-assessment as follows: all RGSC current employees and volunteers do not have, as a result of any of the checks performed, any permanent bars to employment. Since the last monitoring review, there have been a total of none (zero) people who had discretionary bars to employment. The Facility determined that based on the findings from their self-assessment, this provision is in substantial compliance because 100% of the current employees and volunteers do not have a criminal history that would preclude them from working. By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. 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.	

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

1. The Facility needs to determine the root cause associated with its high rate of untimely reporting of abuse and neglect and develop and implement corrective action plans commensurate with the conclusions drawn from the root cause analysis. (Provisions D.1, D.2.a, b, and c).
2. Develop a comprehensive corrective action plan that would significantly improve the processes associated with review of non-serious discovered injuries and the investigation reports that result from these processes (Provision D.2.a).

3. Develop a corrective action plan that would ensure guardians who are not present at an ISP meeting receive the information on abuse reporting they would have received if they were in attendance (Provision D.2.d).
4. Expand the scope of semi-annual audits of significant incidents to include a comprehensive data review of injuries, restraints, peer-to-peer aggression and other data which may identify situations requiring investigation (Provision D.2.i).
5. Establish policy and procedure, with DFPS, that can reasonably protect testimonial evidence and lead to improved investigations (Provisions D.3.d and e).
6. Develop a comprehensive corrective action plan directed at critically reviewing investigation reports, following up with investigative agencies as needed, and determining that investigation findings have been developed accurately and are consistent with fact patterns presented in the investigation reports (Provisions D.3.f, g, and h).
7. Establish a QA process which can determine if administrative and programmatic actions taken in response to investigation findings have resulted preventing recurrence of the same or similar issues which were the subject of the investigations (Provision 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 Self-Assessment and Action Plan 2/13/12 2. RGSC Section E Presentation Book 3. DADS Policy 3.1 Quality Assurance 1/26/12 4. SA-PIC meeting minutes for September 2011, October 2011, November 2011, December 2011, and January 2012 5. RGSC Quality Assurance Plan 2/7/12 6. RGSC Improving Organizational Performance Program 1/4/12 7. RGSC SOP QM 100.003 Staff Composition and Responsibility 6/11 8. RGSC Monitoring Tools and Summary Reports prepared for SA-PIC meetings (undated) 9. RGSC Monthly Trend Analysis Report January, 2012 10. RGSC Quarterly Trend Analysis Report 9/1/11 to 11/30/11 11. RGSC Injury Logs (witnessed and discovered) 9/1/11 to 2/27/12 12. Corrective Action Plan (CAP) Reporting 2011 from 9/1/11 to 2/8/12 13. Sample of completed SA monitoring tools 14. Incident Management Review (IMRT) minutes for 15 meetings from 11/1/11 to 1/31/12 15. Self-Advocates meeting minutes 9/20/11, 11/22/11, 12/20/11, and 1/24/12 16. Under Reporting Audits for September 2011, October 2011, November 2011, December 2011, and January 2012 17. UIR Audits September 2011, October 2011, November 2011, December 2011, and January 2012 **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 **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 2/26/12 2. Settlement Agreement Performance Improvement Council (SA-PIC) 2/29/12
	Facility Self-Assessment: The self-assessment reported it was in compliance with one of the five provisions of this section of the SA. The Monitoring Team determined that none of the five provisions are in substantial compliance. The Facility's methodology for its self-assessment rating is described in each provision. For example, for Provision E.1, the Facility stated it reviewed completed monitoring tools and internal and external program audits. It also identified a concern that data trending was not consistent in all areas of the ICF-ID program. For Provision E.2, the Facility self-assessment reported that it maintained a system for Corrective Action Planning that contained the necessary components to substantiate compliance. However, the Monitoring Team believes this provision requires the development of CAPs that address systemic issues and that this provision requires some methodology to determine that CAPs have, or have not, prevented the recurrence

	of problems. Action steps taken with regard to E.2 did not address either subject. Action Plans submitted with the self-assessment did not address concerns related to the QA process identifying systemic issues (and related corrective action planning) and the absence of evaluative methodologies to determine that CAPs were, or were not, effective in remedying or reducing the problems originally identified.
	Summary of Monitor's Assessment: The Facility had adopted a methodology for review of data referred to as CATW2. CATW2 refers to **C**heck, **A**sk, **T**hink, **W**hy, and **W**hat. This methodology was developed by the Facility to encourage those reviewing data reports to engage in critical thinking. The Facility is to be commended for the development of this methodology, as it should help facilitate the use of data in identifying systemic issues. RGSC had improved its QA processes by adding a number of data items to be tracked longitudinally. Continued improvement in tracking, trending, and use of data remains necessary. This is especially relevant when contemplating data analysis that results in the identification of systemic trends and developing responses (action plans) to issues which data suggests are systemic in origin. The Monitoring Team commends the Facility for revising trend data to include longitudinal data. Longitudinal data is especially important at RGSC because the ICF-ID program is so small. Most data sets are too small to analyze and develop rational responses if only looking at one month of data. There are still additional revisions to longitudinal tracking that should be considered. The RGSC maintained a written Quality Assurance Policy and Plan. The Plan was comprehensive and ample evidence existed that demonstrated the plan was being implemented. Many CAPs resulted from plan implementation. These CAPS were tracked and not closed until evidence was collected and provided to the QA Department to validate completion. There was little evidence that the RGSC quality assurance 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 step in the maturation of the quality assurance at RGSC. The Monitoring Team did not identify substantive activity occurring that would measure whether any set of activities generated in multiple CAPs were directed at similar subject matter (i.e. Incident Management or infection control), and while implemented, were effective in preventing the recurrence of problems. This level of data analysis will be necessary in order to establish compliance with this provision of the SA. The Facility is to be commended for the system it has put in place to identify the need for a CAP, track CAP assignments and completion status, periodically review CAP status, and require evidence to substantiate CAP completion. CAP evidence reviewed by the Monitoring Team for a small sample confirmed the effectiveness of this system.

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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 self-assessment 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 remains necessary. This is especially relevant when contemplating data analysis that results in the identification of systemic trends and developing responses (action plans) to issues which data suggests are systemic in origin. Note: The Facility had adopted a methodology for review of data referred to as CATW2. CATW2 refers to **C**heck, **A**sk, **T**hink, **W**hy, and **W**hat. This methodology was developed by the Facility to encourage those reviewing data reports to engage in critical thinking. The Facility is to be commended for the development of this methodology as it should help facilitate the use of data in identifying systemic issues. Throughout this section of the report whenever there is reference to review or analysis the CATW2 methodology would have been used unless otherwise noted by the Monitoring Team. The Facility reported it had engaged in the following activities to conduct its self-assessment: • Reviewed Trend Analysis Reports for restraint, injuries, falls, unusual incidents, ANE, and peer to peer aggression. • Reviewed completed the DADS State Office Settlement Agreement Monitoring Tools quarterly. • Conducted a monthly review of reports as required by the Facility Quality Assurance (QA) Plan. • Reviewed DADS Medical Provider External Audit and the DADS Medical Provider Internal Audits. The Facility reported the results of its self-assessment as follows: • Six out of six Trend Analysis Reports were presented to Incident Management Review Team (IMRT) for review and analysis. This demonstrated that trend reports are routinely reviewed by the IMRT. The content of trend reports was modified in December, 2011 to include additional longitudinal data. Prior to this IMRT review consisted primarily of a review of just the most current month data. Documentation of the January, 2012 IMRT review (of December, 2011 data) demonstrated this practice was continuing. IMRT Analysis and selected opportunities for improvement were completed for six of six Trend Analysis Reports and provided to the Settlement Agreement Performance Improvement Committee (SA-PIC) for review from September through December, 2011.	Noncompliance

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		DADS State Office Monitoring Tools were completed, entered into the appropriate databases and findings reviewed and analyzed by the SA-PIC for all tools for each quarter in this reporting period. • Review of the SA-PIC meeting agenda/minutes for the November, 2011 meeting reported that 96% of expected reports were submitted for review. One report was not submitted as required by the QA Plan. Review of SA-PIC meeting agenda/minutes for December, 2011 meeting also shows one report not being submitted as required by the QA Plan. The reports for both meetings were from the Psychology Department and the need for submission was addressed by the ICF Program Director. • An External Medical Provider Audit was completed in June, 2011. Medical Provider Internal Audits were conducted for the months of July through October, 2011. A report of findings from the completed Medical Provider Audits had been pulled from the database and provided to the ICF Services Physician and RGSC Clinical Director for corrective action. This action was reported at SA-PIC. The Facility determined that based on the findings from their self-assessment, this provision is not in substantial compliance because data trending in all areas of the ICF Program by program area, home, shift, by individual, by staff (as applicable), and day of the week is not consistent in all areas of the program. The Monitoring Team commends the Facility for revising trend data to include longitudinal data. Longitudinal data is especially important at RGSC because the ICF-ID program is so small. Most data sets are too small to analyze and develop rational responses if only looking at one month of data. There are still additional revisions to longitudinal tracking that should be considered. For example, the Allegations Trend Report reports the day of the week, shift, and hour of the day for allegations for the report month. It may be useful to track these data over an extended period of time as it could have implications for staffing, supervision, and activity levels of individuals. For example, if allegations are disproportionally represented on certain days of the week, certain shifts, or in clearly delineated time windows, it's conceivable that activity level, staffing ratios, or supervisory presence may need to be examined. At a minimum these data, when reviewed longitudinally, can give clues as to administrative and programmatic processes that may contribute to outcomes, positively and negatively. The Unusual Incidents Trend Report may have been modified to report only non-DFPS reportable incidents (DFPS reportable incidents are reported in the Allegations Trend Report), as the report provided to the Monitoring Team did not show incidents that involved allegations of abuse, neglect, or exploitation. This report, in order to lend itself	

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		to trend analysis should report on all unusual incidents. The DFPS reportable incidents (the Allegations Trend Report) could be a subset of the Unusual Incidents Report, and could, as it does now, be a separate document since DFPS reportable incidents represent the most serious unusual incidents and would logically be subjected to trend analysis separate from trend analysis of all unusual incidents.	
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 self-assessment reported substantial compliance with this provision of the SA. The Monitoring Team does not concur primarily because the level of data analysis undertaken by the Facility was not yet sufficient to identify systemic trends that need substantive corrective action. The Facility reported it had engaged in the following activities to conduct its self-assessment: • Reviewed Trend Reports presented to IMRT to identify any data which appeared to represent an outlier. The IMRT was required to take action on any outliers or areas of concern noted in the data. • Reviewed Corrective Action Plans (CAPs) initiated for any outliers noted during the review of findings from the DADS State Office Monitoring Tools review. • Reviewed CAPs initiated for any measures in the QA Plan which did not meet established expectations. CAPs were sent to the Department/Individual responsible and their supervisor and tracked for completion through SA-PIC. • Reviewed open CAPs, team assigned and status at SA-PIC monthly meetings. The number of CAPs opened and closed during the previous month was also reported and reviewed. The results of the self-assessment as reported by the Facility were: • CAPs initiated from the Trend Reports to IMRT were included in daily IMRT meeting reports and reviewed for initiation and completion status daily. CAPs were closed when all required documentation to address the CAP was submitted to the Settlement Agreement Clerk. • CAPs initiated from the analysis of the Monitoring Tools review were reviewed for initiation and completion the month following the quarterly report at SA-PIC. The review completed in August, 2011 for Quarter Four of Fiscal Year 2011 reported a compliance rate of 100%. A 100% compliance rate (of initiation of CAPs) was also reported for the first two quarters of Fiscal Year 2012. • A report of all open CAPs from the QA Plan and initiated within the ICF Program was reviewed for determination of date of initiation and date of completion. This was reported monthly at the SA-PIC. • A report of all open CAPs was reviewed monthly at each SA-PIC meeting. A report of	Noncompliance

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		closed CAPs reports date of when initiated, date closed, and the team/person responsible for the CAP. This is also reported to SA-PIC monthly. The self-assessment reported that since the last visit by the Monitoring Team there have been 339 CAPs initiated and 356 CAPs closed. The Facility determined that based on the findings from their self-assessment, this provision was in substantial compliance because CAPs are initiated when required and sent to the team/person responsible for action. The RGSC maintained a written Quality Assurance Policy and Plan. The Plan consisted of the monitoring matrix required by DADS QA policy. In this regard it was comprehensive and addressed required monitoring of SA provisions. Evidence existed that demonstrated the plan was being implemented. Many CAPs resulted from plan implementation. These CAPS were tracked and not closed until evidence was collected and provided to the QA Department to validate completion. An issue with the QA policy and plan is that it did not appear to represent a broader set of activities that effect organizational performance. The design and implementation of the QA plan focuses primarily on SA monitoring tools and does not analyze and present data that could be used to develop organizational performance improvement initiatives. For example, the formal QA process did not appear to address any substantive information regarding clinical outcomes. Nor did it address obvious issues presented in the consumer satisfaction survey such as the need for more activities, the concern for noise levels, and clothing issues. A comprehensive QA process that can result in performance improvement initiatives should include multiple inputs including data from regulatory reports (CMS 2567's); reports (anecdotal and written) coming from DADS subject matter experts, outside consultants, DFPS, OIG, and others; consumer satisfaction surveys and, data collected from self-advocacy group meetings, family member meetings, and other stakeholders. Additionally, the Facility QA process did not appear to be using available data to identify individuals with concerns across multiple areas (e.g., injuries, incidents, hospitalizations or ER visits, restraints, etc.), and use these data to identify possible systemic issues. To the extent such review takes place it appropriately occurs through the IDT and risk assessment process; however, in order to facilitate organizational performance improvement such data needs to be reviewed and analyzed from a facility-wide perspective. The RGSC had a Settlement Agreement Program Improvement Council (SA-PIC). This group performs the same functions as the QA/QI Council described in the DADS QA	

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		Policy and provides a facility-wide forum for the review of the CAP process and results. It was reported this group met twice a month. One meeting is a formal meeting to review data, discuss trends, and identify the need for action plans. 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. The second meeting of the month was characterized as more problem solving in nature. Attendance and minutes are not kept of this meeting. Although there is potential for this group to identify systemic issues and develop CAPs and improvement initiatives to address the issues, discussion did not apparently 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. 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 reliability audits conducted 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. This, along with inter-rater reliability checks of monitoring and auditing conducted by residential units and facility departments would, ostensibly, be the primary focus of the QA department.	

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		The QA activity in place at RGSC consisted largely of administrative steps directed at this first strategy. The Monitoring Team observed very little activity directed at the second strategy. At the last review, 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. The Facility had taken a first step in this direction by assigning CAPs to "reporting teams" which tended to focus on administrative functions such as the Incident Management, Administrative Death Reviews, or Infection Control. The CAP reporting system is now organized by reporting team. This may facilitate the identification of systemic issues within a functional area (such as the review of DFPS reports) but would not likely facilitate the identification of systemic issues that are cross-functional and interdisciplinary in that the issue(s) may intersect with multiple reporting teams. The Facility should consider additional strategies to code CAPs such that systemic issues might be more easily identified. For example, CAPs in many functional areas may address a deficiency in staff performance that is addressed through training/retraining of a specific staff person or a group of staff. If the CAP data related to this topic were able to be periodically merged in a special CAP report the analysis may lead to a systemic oriented CAP targeting improved training/retraining methodologies and competency testing. There was little evidence that the RGSC quality assurance 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 step in the maturation of the quality assurance at RGSC. Finally, the Monitoring Team did not identify substantive activity occurring that would measure whether the set of activities generated in multiple CAPs directed at a similar subject matter (i.e. Incident Management or infection control), while implemented, were effective in preventing the recurrence of problems. This level of data analysis will be necessary in order to facilitate compliance with this provision of the SA.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	The self-assessment reported lack of compliance with this provision of the SA and the Monitoring Team concurs. The Facility reported it had engaged in the following activities in conducting its self-assessment: • The Facility reviewed 10 randomly selected closed CAPs per month from the CAPs	Noncompliance

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		database to ensure they were sent to the individuals responsible with a copy to their supervisor. The Facility reported that the results of the self-assessment were as follows: • CAP Completion Audit Findings from September through December, 2011 reported an average compliance rate of 53% of the 10 CAPs that were sent to the department/staff responsible for implementation as well as their supervisor. 09/2011 – 30% 10/2011 – 30% 11/2011 – 50% 12/2011 – 100% 01/2012 – 70% The Facility determined that based on the findings from this self-assessment, this provision is not in substantial compliance because the SA Clerk was not aware that supervising staff were to be copied on all CAPs until December, 2011. Since the expectation has been noted, 100% of CAPs are now being sent to the staff member/department/team responsible and their supervisor. However, due to the random sample selected for each review, and the timeliness of CAP completion, the Facility reported it had been unable to sustain adequate compliance. Random checks completed by the Monitoring Team validated the results of the self-assessment.	
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 self-assessment reported lack of compliance with this provision of the SA and the Monitoring Team concurs. The Facility reported it had engaged in the following activities to conduct its self-assessment: • The Facility conducted a review of10 randomly selected closed CAPs per month from the CAPs database to ensure full implementation prior to closure, supporting documentation to close the CAP, and whether or not CAPs were implemented in a timely manner. The Facility reported the results of its self-assessment as follows: • CAP Completion Audit Findings from September through December, 2011 reported an average compliance rate of 42% of the 10 CAPs reviewed that were completed within timeframes established.	Noncompliance

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		09/2011 – 60% completed within timeframe provided. 10/2011 – 20% completed within timeframe provided. 11/2011 – 30% completed within timeframe provided. 12/2011 – 60% completed within timeframe provided. 01/2012 – 40% completed within timeframe provided. 100% of the 10 CAPs reviewed contained the supporting documentation to close the CAP. The Facility determined that based on the findings from this self-assessment, this provision was not in substantial compliance because only 42% of CAPs reviewed were completed within the timeframes provided. The Facility is to be commended for the system it has put in place to identify the need for a CAP, track CAP assignments and completion status, periodically reviewing CAP status, and requiring evidence to substantiate CAP completion. CAP evidence reviewed by the Monitoring Team for a small sample confirmed the effectiveness of this system. As noted in Provision E.2, 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 (or a set of related CAPs) 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 self-assessment reported lack of compliance with this provision of the SA and the Monitoring Team concurs. The Facility basis for non-compliance was the lack of any CAPs that required modification, and therefore, the effectiveness of modified CAPs could not be tested. The Monitoring Teams basis for non-compliance is different. As described above, the Facility did not appear to have a method to determine the effectiveness of a CAP, only that the steps in a CAP had, or had not, been carried out, and the timeliness in which they had been carried out. Without an evaluative methodology to determine the effectiveness of a CAP it is unlikely a determination could be made that a CAP requires modification. The Facility engaged in the following activities to conduct its self-assessment: • The Facility reviewed 10 randomly selected CAPs per month to determine if modification to the CAP was initiated or necessary.	Noncompliance

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		• The Facility reviewed any modified CAPs to determine if implementation occurred as specified in the CAP. The Facility reported the results of its self-assessment as follows: • Of the 40 CAPs reviewed between September and December, 2011, no CAPs were modified. The Facility determined that all CAPs implemented were effective in addressing the concern noted; therefore, zero of 40 CAPs reviewed required modification. The Facility determined that based on the findings from this self-assessment, this provision was not in substantial compliance as the Facility was unable to determine compliance as no Corrective Action Plans in the sample reviewed required modification. As noted above, the Monitoring Team also determined noncompliance but for a different reason.	

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 Self-Assessment and Action Plan 2/13/12 2. RGSC Section F Presentation Book 3. DADS Policy 004 Personal Support Plan Process 7/30/10 4. RGSC SOP MR 600 01 Personal Support Plan Process (Integrated Protections, Services, Treatments, and Supports) revised 4/11 5. RGSC SOP ICF-MR 600 02 Development and Monitoring of Individual Program Plans Personal Support Team Approach revised 2/10 6. Supporting Visions Tier 2 & 3: Personal Support Planning Workbook for training 7. Individual/ Personal Support Plans (ISPs/PSPs) for Individuals #13, #26, #27, #55, #59, #61, #63, #77, #80, #84, #85, #88, #97, #121, and #139 and supporting assessments for Individuals #27 and #55 8. Personal Focus Assessment (PFA) for Individuals #27 and #55 9. Active Records for Individuals #8 and #46 10. QMRP Facilitation Skills Performance Tool 11. December 2011 ICF Monthly Delinquent Assessment Report dated 1/3/12 12. Annual Assessments Filed within 10 Days for period of 8/1/11-1/31/12 13. Email of 3/1/12 from Rosa Sanchez to Mary Ramos re: clarification on PSP assessments tracking log and HIM audit **People Interviewed:** 1. Janie Villa, QDDP Coordinator 2. QDDPs Rebecca Olivares, Laura Morales, and Karina Serratos **Meeting Attended/Observations:** 1. ISP Meeting for Individual #97
	Facility Self-Assessment: The Facility provided two documents intended to present the status of current efforts to comply with the Settlement Agreement. The first was a Self-Assessment reflecting measures of progress. The second was the Action Plan that outlined the steps the Facility had identified as critical to satisfying the Settlement Agreement. The Facility's Self-Assessment Report included the activities the Facility engaged in to conduct the self-assessment and self-ratings based on the findings. The Facility found no provisions of this Section to be in compliance. The Monitoring Team concurs. In some cases, the activities and data used by the Facility needed to be supplemented; the Monitoring Team addresses that below for a few provisions. Additional information can be found by reviewing the content of the Assessment of Status.

	For Provision F1a, the Facility rated noncompliance due to lack of all IDT members participating in ISP meetings and QDDPs needing retraining on Facilitation Skills. The Monitoring Team agrees but also points out that monitoring of implementation needs improvement. For Provision F1b, the Facility provided data on attendance at ISP annual planning meeting. The Monitoring Team finds that to be a useful and appropriate measure. However, the Monitoring Team points out that participation in planning goes beyond attendance at annual planning meetings and involves participation in other planning activities. For Provision F1c, the Monitoring Team again considers the type of data used in the self-assessment to be appropriate (although, in this case, there were varying reports with different data, as reported in the Assessment of Status) but also reminds the Facility it needs some means to evaluate comprehensiveness of assessments. For Provision F2c, an additional consideration is the need for greater detail and clarity in the ISPs as to the activities to be implemented and specifically who is responsible for implementation and monitoring. For Provision F2e, the information provided in the self-assessment provides a good process for evaluation, but it is limited to psychology monitoring of PBSP implementation. Similar evaluation should be done for other ISP actions. The Action Plan is ambitious, includes sequential activities as needed, and could move the Facility well forward toward compliance. The concern would be whether the Facility would be able to define and monitor accurately some complex issues, such as whether the ISP contains strategies to support functional learning, and whether treatment plans are integrated into the ISP.
	Summary of Monitor's Assessment: The Monitoring Team found all provisions to be noncompliant. The Facility had made progress in a number of areas. The QDDP Coordinator had initiated processes to monitor and provide peer review of ISP facilitation. QDDPs had received training on facilitation. The QDDPs had not yet ensured that members of the IDT complete assessments timely so that IDT members could review prior to the ISP annual planning meeting, attend and participate as needed in the ISP annual planning meeting, and monitor implementations of treatments, services, and supports. IDT participation in the ISP annual meetings provided evidence of integrated discussion, but some interventions such as Physical and Nutritional Management Plans did not show evidence of integration in planning or into the ISP. Professionals did not consistently include in their assessments a determination of the appropriateness of movement to a more integrated setting. Nevertheless, discussion in an observed ISP annual planning meeting focused on the supports needed for movement, and there has been a significant increase in the number of individuals referred for movement.

	The ISP is to be developed in a way that addresses an individual's preferences, strengths, and needs. Identification and documentation in the ISP of preferences focused on preferred foods and activities but did not generally identify preferred lifestyles, and therefore did not lead to a focus on goals that would be functional in a more integrated setting or could overcome obstacles to movement. Furthermore, the preferences that were listed were not always addressed in the ISP action plans. Supports and services were not integrated into the ISP. Some essential supports, such as medical and PBSP actions, were not included in the ISP and remained as separate plans. Strategies to achieve goals were not specified, and responsibility for implementation and monitoring was identified by position title rather than by name of the responsible individual. Although there had been training for staff who participate in ISP development, there was a lack of competency-based training for staff who implement the planned strategies.

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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:		
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 Facility assigned the Qualified Developmental Disabilities Professional (QDDP) to facilitate the work of the Interdisciplinary Team (IDT) for each individual. The Facility had four QDDPs, but one QDDP had recently been reassigned to Human Rights Officer (leaving three QDDPs to share the caseload), and the Facility was in process of filling this vacancy. Of the three QDDPs at the Facility at the time of the compliance visit, three (100%) had participated in Facilitation Skills training according to the Facility self-assessment. One had completed the DADS QMRP Facilitation Skills Performance Tool requirements to be certified competent. The structure of an IDT was in place at RGSC. Observation of the ISP annual planning meeting for Individual #97 revealed that the QDDP assigned to the individual led the meeting and facilitated planning. Integrated discussion involving several IDT members occurred for some topics, but there was greater emphasis on discipline reports than had been seen at recent visits; the Facility needs to maintain an emphasis on having IDT members review assessments from all disciplines prior to the meeting so planning can	Noncompliance

#	Provision	Assessment of Status	Compliance
		focus on integrating treatments, supports, and services. The assigned QDDP was responsible also for monitoring treatments, services, and supports. QDDPs did not consistently ensure the IDT members for all disciplines completed assessments or monitored and revised treatments, services, and supports as described in Provisions F2a6, F2d, K4, and V4. As noted above, assessments will need to be completed in advance of ISP annual planning meetings in order to permit review by all IDT members prior to the meeting. A QDDP Coordinator was assigned to oversee and facilitate the work of the QDDPs. Per interview with the QDDP Coordinator, she had developed processes to monitor ISP meetings including annual planning and quarterly review meetings. In addition, a peer review process had been initiated so that each QDDP will complete the ISP monitoring tool at ISP meetings facilitated by another QDDP; there is a plan to then have the peer also audit the resulting ISP, but that had not yet been implemented. Therefore, although one person from the team facilitated the IDT, there remained a need to improve both facilitation and monitoring in order to comply with this provision.	
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 Monitoring Team reviewed ISPs and sign-in sheets for Individuals #26, #27, #55, #59, #63, #77, #84, #85, #88, and #139, and attended the ISP annual planning meeting and reviewed the sign-in sheet for Individual #97. • The individual was documented as present at six of the eleven meetings (55%). Family or LAR were documented as present for and additional meeting and also for two meetings attended by the individual. • Most IDT members for whom the ISP indicated a need to participate were documented as attending. There was at least one direct care staff or home supervisor/manager documented as present at each meeting. However, there were also some specific absences. o Physicians did not attend most meetings. In many cases, there was no specific medical issue reported, and nurses were documented as attending. However, some examples were more problematic. ▪ Individual #88 was reported to have deep vein thrombosis and seizures, but no physician participated. ▪ Individual #85 had osteoporosis, and concern was expressed about continuing weight loss. o Psychiatrists did not participate for some individuals who took psychotropic medications, including Individual #27 (polypharmacy), #55, #59 (polypharmacy), #63 (polypharmacy), #84, and #139. o No dietitian or nutritionist was documented as present for Individual	Noncompliance

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		#139, who was on a chopped diet and a diet to control diabetes. 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. Compared to findings at prior compliance visits, there was increased attendance documented for habilitation services staff (occupational, physical, and speech therapists); these staff were documented as present at all meetings at which the needs of an individual would dictate the need for them to attend (and, for one meeting where there did not appear to be a need for the speech therapist to participate, the IDT established a plan for a new communication assessment to be completed). The report from the compliance visit of August 2011 stated that Physical and Nutritional Management Plans (PNMPs) were not formally developed with input from the IDT, home staff, medical and nursing staff. One step taken by the Facility was to establish attendance by the PNMT nurse at all ISP annual planning meetings. Nevertheless, as reported in Provision O1, PNMPs were not clearly developed with input from all members of the IDT or reviewed consistently by the IDT. Required participation in IDT meetings is not limited to the ISP annual planning meetings but should occur as needed.	
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.	<u>Completion and Timeliness of Assessments</u> The Monitoring Team found various reports provided widely varying information about completion of assessments. Some documents provided showed low completion rates, whereas other showed higher completion rates, and neither matched the data provided in the self-assessment or in verbal reports from staff. When the Monitoring Team attempted to clarify the discrepancies, explanations given included: • Differing definitions—the tracking log of annual assessments that identified 30% completion involved checking whether assessments were completed within 10 days of the annual ISP meeting, whereas data from Health Information Management (HIM) showing completion rates usually greater than 90% were based on assessments filed within 30 days following the ISP annual planning meeting. • Recency—QDDPs, in an interview, reported that they had been told completion of assessments had improved recently and was not approximately 66%. However, the self-assessment provided data from 9/1/11-11/30/11 showing	Noncompliance

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		rates similar to the data provided by HIM. Furthermore, audits of records from December 2011 and January 2012 found numerous missing or outdated assessments. Although it might be valuable to have data on both assessments provided for the ISP annual planning meeting and assessments completed following that meeting, the Facility needs to determine what information is most valuable for planning services and be sure to conduct those and complete them timely. In many cases, assessments are needed for planning sessions; in other cases, new assessments are needed throughout the year when an individual's health or behavioral status changes, or when there was lack of response to an intervention. • As reported in Provision K6, documentation did not reflect, however, that SFAs had been reviewed as often as necessary based upon response to the PBSP. Assessments were not always completed as needed. • As reported in Provision K6, progress in completion of psychological assessments had been made, with nearly everyone having an annual psychological assessment. However, documentation on completion of psychological assessments varied. Information from the Facility indicated that as many as 56 individuals had not been provided an intellectual or adaptive assessment in the past year. • As reported in Provision M1, there had not been improvement in assessment of individuals with acute changes in health status. • As reported in Provision O2, two of 17 Individuals (11%) 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. <u>Comprehensiveness and Quality of Assessments</u> Assessments were still not routinely of sufficient quality and comprehensiveness to identify each individual's strengths, preferences, and needs, although some disciplines had made progress. For example: • As reported in Provision K5, Structural and Functional Assessments (SFAs) showed considerable improvement over the last compliance visit. To meet all requirements, SFAs must integrate into the assessment process consideration of environmental functions of behavior and symptoms of mental illness. • As reported in numerous individual examples in Provision L1, physicians appropriately responded to results of assessments but also found examples in which health issues were not reported in assessments, such as the lack of report	

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		of problems with gait for Individual #15. • As reported in Provision M2, the Nursing Department had made minimal improvement toward achieving compliance with the requirements regarding assessments. No improvement was noted in analyses and summaries of clinical data. • As reported in Provision R2, communication assessments were neither detailed nor comprehensive enough to allow for the identification of potential expansion of communication skills or of strategies for the use of communication devices.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	<u>Extent to which assessment results are used to develop ISPs</u> Assessments must be timely in order for them to be used in developing integrated services and supports in an ISP. As reported above in Provision F1c, the varying reports made it impossible to assess precisely what proportion of assessments were available for use in planning the ISP. However, the ISP Tracking Log reported the timeliness of assessments, by discipline, for ISPs conducted between 8/1/11 and 1/31/12. This reported an overall compliance rate of 30%, meaning only 30% of assessments needed for an ISP meeting were completed within 10 days of the meeting, and filed in the shared drive, for other members of the IDT to review prior to the ISP meeting. Some examples of compliance rates by discipline are: • Health risk assessment 0% • Functional skills assessment 25% • OT/PT assessment 61% • Comprehensive functional assessment 9% • Adaptive living skills assessment 43% • Speech assessment 20% • Nursing summary 17% • PNMP 25% The Facility did not have a process to assess how the results of assessments are used in developing, implementing, and revising ISPs. The peer audits of ISPs being planned by the QDDP Coordinator might provide a venue for such monitoring. This would require clear definitions and guidance about how to determine that results were or were not used. The Monitoring Team observed the one ISP meeting that was held during the week of the review. Review of risks was spread throughout the discussion, so that risks were discussed when relevant to the specific topic being addressed; for risk areas that were not otherwise discussed, the QDDP specifically raised the areas for discussion. Throughout the discussion the team members made corrections and additions to the draft Risk Screening Assessment risk level ratings and respective rationales, as well as	Noncompliance

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		from the previous risk level ratings. The active medical record was referred to during the meeting to clarify clinical issues., and results of assessments were discussed when relevant. However, available assessment results were not always considered when planning. For example: • As reported in Provision S1, the narrative in ISPs generally reflected that skill acquisition goals were selected based upon the subjective opinion of staff attending the ISP meeting or anecdotal observations for which no substantiating data were presented. There were weaknesses in the application of the FSA. Numerous circumstances were noted where the findings of the FSA were not in agreement with the goals included in the SPOs. This was confirmed through review of the sample of ISPs listed in Provision F1b. An example can be found for Individual #5, for whom the ISP had a goal to select a meal from a picture menu with physical prompts, although the Speech-Language evaluation stated the individual lacked interest in identifying pictures and did not label objects; this would indicate a choice of a goal that is unlikely to succeed without selecting intermediate objectives to develop skills in matching pictures to items. Also, the Speech-language assessment stated that the individual could follow simple commands (from other portions of the assessment, it appeared these might have been more successful when commands are in Spanish), and the Functional Skills Assessment stated the individual follows one-step directions with gestural cues, but all goals involved physical prompting, and there was no indication that either simple directions or gestural cues would be attempted. • Intervention plans related to positioning, oral care, and medication administrations were not based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies. For example, Individual #121'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. • As reported in Provision L1, for Individual #115, physician assessment of clinical condition and PT/OT assessment were appropriate, and follow-up was good, but there was no documentation indicating that the IDT had addressed the orthopedic concerns comprehensively, and the ISP did not reflect the condition or necessary supports and services.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United	While DADS policy and the SA explicitly state that the decision of the LAR regarding community placement is to be honored, the ADA and Olmstead decision call for a person to be served in the most integrated setting appropriate to their needs as determined by qualified professionals unless the individual (or LAR) specifically objects. The IDT as a	Noncompliance

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	States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	whole, and the members individually, serve as the state's qualified professionals for this purpose. Each SSLC team member should include in his/her assessment/evaluation a recommendation regarding the individual's appropriateness for transition to a more integrated setting, and delineation of the supports the individual would need. The professionals' recommendation should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition. This has not yet been fully implemented. As reported in Provision T1b3, assessments by clinicians did not routinely include determination of most integrated appropriate setting nor indicate how the information in assessments might lead to a decision on type of setting. The ISP annual planning meeting observed for Individual #97 began with discussion of appropriateness of movement to a more integrated setting, and much of the focus of the meeting was on identifying supports that would be needed for this to be successful. Although only one of seven discipline assessments (14%) included a determination of appropriateness of a more integrated environment (even though two others listed supports that would be needed), and although the individual displays complex behaviors and has medical conditions that will require support, the IDT agreed to propose to the individual's parents (who were unable to attend) that they consider referral to group homes near them. Further discussion led to suggestions to address behavioral issues that could become obstacles to movement if private providers could not provide the needed supports, as well as activities that might be preferred for day activity services. Because the final ISP was not available to the Monitoring Team prior to drafting this report, the relationship of the ISP goals and supports to this discussion could not be assessed. Assessment of the sample of ISPs listed in Provision F1b and, as noted in Provision F1d, concerns about the relationship of information in assessments to supports and services, indicate that the IDTs still must improve their identification of supports needed for movement to a more integrated environment and to tie those to action plans for services at RGSC. Nevertheless, a positive finding was that the ISPs and the observed planning meeting showed that staff at the Facility were not identifying unnecessary obstacles to movement to a more integrated setting and were making efforts to identify how the ISP could address issues that could affect success of such movement. There had been a significant increase in the number of individuals referred for movement to a more integrated environment.	

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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:	The ISP format included narrative minutes as well as specific headings. The narrative section included a wide range of issues discussed during the meeting in no consistent order. As a result, it is difficult to identify clearly that specific topics are covered. For example, guardianship status was described in the narrative in some ISPs but not in others, but there is no heading where a summary statement is made of the status of guardianship, any needs for action on guardianship, and who will be responsible for that action. The Monitoring Team is aware that DADS is in process of developing and implementing a new standardized format for ISPs and recommends that RGSC staff receive training and monitoring on that format when it is implemented.	
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	This provision of the Settlement Agreement addresses a number of specific requirements, including identification and use of individuals' preferences and strengths, prioritization of needs and explanation for any need or barrier not addressed, and identification of supports needed to encourage community integration. Each of these is addressed separately below. <u>Policy</u> DADS Policy #004 at II.D.4 indicated that Action Plans should be based on prioritized preferences, strengths, and needs. The policy further indicated that the "PST will clearly document these priorities; document their rationale for the prioritization, and how the service will support the individual." RGSC SOP ICF-MR 600 01 Personal Support Plan Process was consistent with DADS policy. <u>Identification and Use of Individuals' Preferences and Strengths</u> The Monitoring Team reviewed ISPs for Individuals #13, #26, #27, #55, #59, #61, #63, #77, #80, #84, #85, #88, #97, #121, and #139. PFAs for Individuals #27 and #55 were also reviewed. ISPs listed a limited number of preferences, most of which involved food or activities and none of which involved preferred lifestyle (except for preference to be with family). The PFA for Individual #27 identified a preference to continue to live at RGSC, which was reflected in the ISP. The PFA indicated that she becomes upset when people take her personal items, and that she enjoys outings and money; the ISP included those two preferences and addressed what upset her by establishing a goal for her to save money	Noncompliance

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		and put it into a locked box. However, the ISP did not identify a goal to use money in the community, which would address the individual's preferences and encourage community participation. The PFA for Individual #55 did not summarize preferences in priority. It did describe a preferred type of living environment, but that was not carried over to the ISP (although a general statement of "a home with peers" was included in the Optimistic Vision). Additional information about the lack of action planning based on preferences of Individuals #27 and #55 may be found in Provision T1b. Little, if any, information about individuals' specific strengths was discussed in ISP documents. Strengths were not regularly built upon to address other need areas. The Facility must improve its ability to identify prioritized preferences, including preferences for lifestyle, and address them in the ISP. The Facility must also identify strengths and how the ISP can build on them. <u>Identification of Supports Needed to Encourage Community Integration</u> As noted above, the ISP for Individual #27 did not use the individual's preferences for money and outings to identify a goal that would encourage community integration. That was uniformly true for all ISPs reviewed. Goals related to training that would take place on the campus of the Facility. An additional, and similar example, involves Individual #88, who had a preference for outings, and whose money management goal was to count money using model prompts, an activity that could be made both community-based and functional by counting money to make purchases at stores.	
	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;	ISPs did not prioritize preferences or needs and indicate how specific preferences or needs would be addressed but instead simply listed goals for learning or services. Significant needs such as those involving problematic behavior were not addressed through services and supports in the ISPs. PBSPs were not listed in action plans. The ISP must be a single plan that identifies all supports and services to be provided. Because not all supports and services were listed, it was not possible by review of ISPs to determine all the supports and services to be provided. Observable and measurable goals/objectives, treatments and strategies, and necessary supports to attain identified outcomes should be identified in the Action Plans in the ISP. ISPs should include measurable, observable objectives to determine the efficacy of the various action plans. In other words, objectives should be designed to allow the team to determine if the individual is doing better or worse, or remaining stable. In reviewing the limited action plans that had been developed to address individuals' risk areas, the	Noncompliance

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		objectives included were generally inadequate. Descriptions of goals and objectives in the Action Plans in the ISPs were brief and not descriptive. For example, a goal to count money with model prompts does not define the money to be counted (pennies to 10 cents or mixed coins to $10); presumably, clearer objectives would be defined in the Specific Program Objectives (SPOs), but the ISP should identify clearly what is to be worked on and the measurable criteria for completion or to move toward a more independent or complex behavior. Furthermore, as reported in Provision S1, SPOs did not include defined behavioral objectives. Observation of the ISP annual planning meeting for Individual #97 provides an example in which the IDT did identify an issue that, while not listed as a barrier to moving to a more integrated setting, would be expected to affect the likelihood of a successful transition. This involved a behavior that would not be tolerated in many community settings. The IDT addressed this behavior, but, given the format for ISPs, neither a PBSP nor psychiatric treatment would be expected to be clearly listed in the ISP (which was not available for review by the time this report was drafted). However, there was also discussion about the use of communication devices for both general communication and to address the psychiatric condition relevant to the problematic behavior. This discussion showed promise of the IDT addressing supports and services to overcome obstacles to movement.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Numerous examples are provided throughout this report regarding how plans, supports and services were not integrated through the ISPs. ISPs appeared to integrate some, but not all protections, services and supports that individuals required, as this provision of the Settlement Agreement clearly requires. None of the 15 ISPs reviewed (0%) integrated all protections, services, supports, treatment plans, and other interventions provided to the individual. For individual with targeted problematic behaviors, PBSPs were not included in the ISP, although in some cases they were described in the Behavior/Psychiatric narrative in the section describing supports and services. Planned medical interventions were also not listed. The medical, psychiatric, counseling, habilitation therapy, PBSPs, and nursing care plans frequently still were separate plans that were not integrated in any measurable way into the ISP, through, for example, measurable objectives, and did not show an integration of various disciplines and team members. The ISPs listed supports and services through a mix of discipline narratives and narratives about specific concerns. For example, in the case of Individual #88, these narratives in the section titled "The supports and services needed by [individual] in the areas of:" in the Optimistic Living Vision included education regarding living options, Physical environment (home), Employment/day programs/schools, Transportation,	Noncompliance

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		OT/PT, Speech/Audiology, Physical and Nutritional Management, Medical, a list of specific risk areas (most of which were low risk), Behavior/psychiatric, Leisure and recreation, Spiritual, and Relationships. That was the only place the PBSP was mentioned, and therefore any plans to address challenging behaviors was not salient or obvious in the ISP. In the same way, an integrated plan for weight control was in the risk area of Weight; this plan included a reduced calorie diet, walking to work and lunch, and a physical fitness program; the only mention of that in the action plans was a goal to complete a walking/dancing or aerobic routine for 20 minutes when told "it's time to exercise." As written, it is difficult to know how that would include the recommended activities in the Weight narrative; for example, walking to lunch likely takes less than 20 minutes, and it would be nonfunctional to use "it's time to exercise" as a prompt to walk to lunch.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Given that many supports and services (such as PBSPs and most health interventions) were not included in the ISP, the ISP could not specify the staff responsible, the timeframes, or the strategies. Even in the action plans in the ISP, neither the staff responsible nor the timeframes for completion of most action plans were stated. Instead, the staff responsible was listed by job title (QDDP, MRA/Placement Specialist, SLP, Psychologist, PNA, for example), and the completion dates were almost invariably the same as the implementation date or left blank. An exception to the completion date was Individual #27; all completion dates filled in (there was one blank) were the same—one year following the implementation date. ISPs did not describe strategies except to list the level of prompting for the goal (but not the process for how or when to provide prompts). However, as reported in Provision S1, skill acquisition programs did not include description of teaching conditions, schedules of implementation, or other instructions for teaching strategy. Furthermore, most task analysis steps described staff behavior rather than the behavior of the individual that was to be trained. Although this could be considered a form of instruction to staff, it did not include the behavior of the individual that was to be trained and reinforced. In addition, as reported in Provision I3, plans to address risk did not document appropriate functional and measureable objectives or preventative interventions to minimize the condition. Further, although all individuals identified as being at risk for Physical and Nutritional Management (PNM) issues were provided with a Physical and Nutritional Management Plan (PNMP), those PNMPs were not comprehensive regarding strategies for oral care and medication administration and lacked the ddetail needed to ensure safe and consistent delivery of service. Another example was reported in Provision R3. Strategies for communication interventions were not integrated into the ISP.	Noncompliance

#	Provision	Assessment of Status	Compliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	Because SPOs and other intervention strategies were not described clearly enough to specify exactly how they should be implemented, it was not possible to determine accuracy of implementation. Nevertheless, information in this report documents that interventions were not implemented effectively, and therefore did not effectively address the individual's needs. • As reported in Provision K11, the Monitoring Team did not observe staff implementing a formal PBSP. • As reported in Provision R3, staff were unable to identify the shared communication device most appropriate for use by their assigned individuals. This implies that either the strategies were not included in the ISPs or that they were not implemented accurately. Because interventions were not clearly described, and there were few goals that were to be implemented in community settings, it was not possible to assess how practical the interventions would be 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 ISP format used at RGSC did not provide a place to identify the data that would be taken to assess progress, and nearly all action plans in the ISP listed as the place to record "Progress Note." • Data collection for PBSPs, which had included a diverse use of data collection strategies, was no almost entirely limited to frequency counts. Collection of data on replacement behaviors rarely occurred. • Health related data were not described in the ISP, except for general statements such as found in a Staff Service Objective (SSO) for Individual #55 that stated, "Monitor for decreased sleep and any changes in behavior." This was to be entered into progress notes in the CWS. Such a statement does not provide clarity on frequency of monitoring, specifically what is to be monitored, who is responsible for monitoring, or how the data will be reviewed. Similarly, for the same individual, the nurse (not specified by name) was to "continue to monitor next alkaline phosphatase." The frequency of monitoring was listed as "Once." Although there might be a presumption that a separate health care plan document provides more detail, the ISP did not include that detail.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and	As noted in the previous reports, and based on the current review of ISPs, this was an area that required substantial improvement. As is discussed in other sections of this report, the Monitoring Team found a lack of coordinated supports in a number of areas. Review of the ISPs generally showed a multidisciplinary as opposed to interdisciplinary approach.	Noncompliance

#	Provision	Assessment of Status	Compliance
	treatments are coordinated in the ISP.	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 ISP 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 ISP document would facilitate team discussion focusing on integrated planning in the ISP meeting.	
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.	ISPs were accessible to staff as they were included in the active record and both the Residential and Vocational individual notebooks. As indicated throughout this Section of the report, the lack of detail in the action plans and the separation of the PBSP and medical plans, made it difficult to ensure staff were aware of all actions they might be responsible to implement. Although it will be necessary for the separate plans to continue to exist (e.g., PBSPs, PNMPs, health care plans), the goals and objectives of these plans, and the delineation of who is responsible for what with regard to the plans should be incorporated into the overall ISP. The assignment in the ISPs of responsibility to general job classifications (e.g., PNA could include any and all direct care staff) could make it difficult for specific staff to know their responsibilities. As reported in Provision F2a5, staff were not always familiar with or did not implement interventions.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support 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.	All active records reviewed included quarterly review by the QDDP. Because ISPs did not include specific identification of the responsible interdisciplinary team member(s), the Monitoring Team could not ensure monthly review by the appropriate IDT member had occurred. As reported in Provision K4, though, a sample of 11 records, all records included documentation of a monthly review of PBSP data. In addition, slightly over half of the records reviewed reflected that the PBSP had been reviewed or revised if three months had passed without demonstrable progress. Although this left roughly half the individuals lacking the necessary reviews and revisions, it reflected meaningful progress over baseline conditions. As noted for PBSPs, there were instances in which monthly review should have led to action but did not do so timely. For example: • For Individual #134, following the implementation of a PBSP in August 2011, verbal threats increased and remained above pretreatment levels through January 2012. During that same period, measures of mental illness remained at zero. Despite these circumstances, no revision to the PBSP was attempted, but psychotropic medications were increased twice.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The action plan on the Annual Medical Assessment for Individual #4, dated 9/23/11, stated that the individual was to be referred for an endocrinology consultation to address her severe osteopenia, but no documentation was provided to indicate that the consult had been obtained or recommended treatment. • Individuals #36 experienced multiple falls over the period ranging from October 2011 to December 2011 but there was no evidence of assessment or review by the PT, PNMT or PST, and Individual #115 had multiple falls over the period ranging from October 2011 to December 2011 but there was no evidence of PT reassessment.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	<u>Training on Development of ISPs</u> Training on ISPs had been standardized across the SSLCs. Supporting Visions: Personal Support Planning was the standard training curriculum for personal supports planning. The Facility provided the workbook for Supporting Visions Tier 2 and 3: Personal Support Planning; this training had been provided to all staff. Of the three QDDPs at the Facility at the time of the compliance visit, three (100%) had participated in Facilitation Skills training according to the Facility self-assessment. One had completed the DADS QMRP Facilitation Skills Performance Tool requirements to be certified competent. The QDDP Coordinator reported continuing work with the other QDDPs so they can become certified competent. The QDDP Coordinator reported having initiated a process for peer review of ISP planning meetings in which one QDDP observes and provides feedback at a meeting led by a different QDDP. Sign-in sheets confirmed that a second QDDP attended some meetings. This process provides an opportunity to compare performance of the QDDP against what was trained and may help to maintain accurate and effective performance; it may also provide an opportunity to determine whether other IDT members need feedback or retraining on their participation. <u>Competency based Training on Implementation of Plans</u> The Facility did not have a process in place to ensure all staff, including pulled and relief staff, received competency based training on implementation of plans. In fact, there are numerous examples in this report indicating a lack of training. • As reported in Provision K11, there were reports that PBSPs were not implemented, and the Monitoring Team observed lack of implementation of PBSPs. As reported in Provision K12, documentation showed that training on PBSP implementation was conducted but did not show that training was provided to every staff member responsible for implementation. Furthermore, it	Noncompliance

#	Provision	Assessment of Status	Compliance
		was not evident that such training consistently ensured competence rather than simply familiarizing staff with the content of the PBSPs. • As reported in Provision O5, staff were provided with general competency-based training on aspects of Physical and Nutritional Management, but there was no evidence the curriculum required demonstration of competence in some areas. As reported in Provision O4, two of five staff interviewed stated they had received individual-specific training for PNMP strategies. 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, and (as reported in Provision P4) there was also no process to ensure staff responsible for positioning and transferring individuals at an increased risk (including pulled and relief staff) received training on plans prior to working with the individuals.. • The lack of clear description of teaching strategies reported in Provision F2a5 made it difficult to ensure that staff were well trained on the procedures they were to implement. A requirement of competency-based training is a clear statement of the action to be implemented.	
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.	<u>Preparation of ISP for Individuals Admitted</u> Two individuals had been admitted since the last compliance visit. An ISP had been implemented within 30 days of admission for both. <u>Annual Revision of ISPs</u> The Facility provided a log reporting the date of the most recent ISP meeting and the date of the ISP prior to that date. Only one of 70 was not conducted within one year of the prior ISP meeting. This was the case for Individual #13. <u>ISP Put Into Effect Within 30 Days of the ISP Meeting</u> The Facility provided a log reporting the date of the most recent ISP and the date the ISP was submitted to Health Information Management, noting documents are filed in charts within 24 hours of that date. The Monitoring Team received conflicting information regarding ISP implementation. The log presented to the Monitoring Team was the result of a document request that asked that the date each ISP was put into effect be noted. The column "date submitted to HIM" was presumed to be this date. Based on that data, 28 of 70 ISPs (40%) were not put into effect within 30 days of the ISP meeting. Some of the time lapses were extreme. For example: 1. Individual # 96 ISP date was 3/29/11. The ISP was submitted to HIM on 6/22/11. 2. Individual # 66 ISP date was 4/28/11. The ISP was submitted to HIM on 7/11/11.	Noncompliance

#	Provision	Assessment of Status	Compliance
		3. Individual # 8 ISP date was 2/22/11. The ISP was submitted to HIM on 5/17/11. The QDDP Coordinator, when asked about this, reported that ISPs are implemented well before the document is submitted to HIM noting that SPO's are placed in ME books, and staff are trained in SPO's usually within a week after the ISP meeting. She reporting a tracking log was maintained to document this activity and it would provided to the Monitoring Team. None was provided. Moreover, the Monitoring Team considers implementation to occur when all materials needed by the staff who will implement supports and services are in place, so the absence of the SPOs that provide instruction on implementation would indicate lack of implementation.	
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 QDDP Coordinator reported that all QDDPs go to ISP meetings facilitated by other QDDPs and complete the ISP monitoring tool (the Personal Support Plan Meeting/Documentation Monitoring Checklist). The Facility did not provide the Monitoring Team with any data from these monitoring activities and did not describe a process for tracking and trending results or identifying improvements to be made. She also reported a plan, not yet implemented, to have QDDPs do peer reviews of ISPs. The Monitoring Team notes that these activities are a step forward; the Facility should develop a process to track and trend data, and should initiate improvements as needed. Monitoring is also done of the completion of assessments in preparation for ISP planning. As reported in Provisions F1c and F1d, reports of timeliness varied; a report of assessments completed within 10 days of the ISP annual planning meeting showed completion of 30% of required assessments, but other data show much higher completion rates, and the Facility reported completion rates have risen in recent months. Nevertheless, the Monitoring Team could not be sure of the accuracy of these data, given the conflicting reports. The Facility needs to develop a standard report of the availability of assessments prior to the ISP planning meeting and of updated assessments as needed when there are changes in an individual's health or behavioral status, so that problems can be identified and improvement plans put into place. The QDDP Coordinator reported that QDDPs have begun to increase monitoring to ensure implementation of services and supports identified in the ISPs. This is a welcome approach. As noted throughout this report, there was not evidence that this had yet ensured accurate and consistent implementation.	Noncompliance

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

1. Participation by IDT members should extend beyond the meeting into providing input and assistance in the development of programs and service on an ongoing basis (for example, when the PNMP is revised). (Provision F1b)

2. Ensure annual assessments are completed in time so that IDT members can review them prior to the annual planning meeting. (Provision F1c)
3. RGSC staff should receive training and monitoring on the revised DADS ISP format when it is implemented. (Provision F2)
4. The process of establishing the PFA and using it to guide the development of the PSP needs to be more integrated and robust, and should identify preferences for lifestyle as well as food and activities so it can be used to identify needed services and supports. (Provision F2a1)
5. Ensure all QDDPs complete certification on facilitation. (Provisions F2e)
6. Ensure that staff demonstrate competence in providing supports and services before working with individuals. (Provision F2e)
7. Develop a process to track and trend monitoring data from ISP annual planning meetings, and initiate improvements as needed. (Provision F2g)

The following are offered as additional suggestions to the Facility:

1. Consider including in the planned peer monitoring of ISPs a process to evaluate whether results of assessments are used in planning, implementing, and revising ISPs. (Provision F1d)

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 Self-Assessment and Action Plan 2/13/12 2. RGSC Section G and H Presentation Book 3. DADS draft policy #005: Minimum and Integrated Clinical Services 1/12/10 4. RGSC SOP ICF-MR 400-14 Medical Care revised June 2011 5. PSPs, assessments, CLDPs, and other documents reviewed by members of the Monitoring Team, as identified in other sections of this report 6. Integrated Progress Notes (IPN) in Clinical Work Station (CWS) 7. Individual/ Personal Support Plans (ISPs/PSPs) for Individuals #13, #26, #27, #55, #59, #61, #63, #77, #80, #84, #85, #88, #97, #121, and #139 and supporting assessments for Individuals #27 and #55 8. RGSC MR Referral/Consultation Report form 1/3/10 9. Facility database of review of non-Facility clinician recommendations by Facility clinicians 10. IDD Nursing Monthly Consultation Audit (undated, consultation dates 5/20/11-12/6/11) and list of items to be reviewed 11. Consultation reports: Medical for Individuals #3, #19, #51, #60, #69, #85, #86, #88, #91, and #118; MBSS consultations for Individuals #11, #19, #29, #85, #94, and #97 **People Interviewed:** 1. Group interview: David Moron, MD, John Partin, MD, Lorraine Hinrichs, ICF-DD Program Director, and Linda Lothringer, DADS **Meeting Attended/Observations:** 1. Morning Medical Meeting 3/1/12 2. Integrated Support Plan (ISP) annual planning meeting for Individual #97
	Facility Self-Assessment: The Facility found that neither provision was in compliance. The Monitoring Team concurs. The self-assessment reported a high percentage of assessments to be completed timely. However, the Facility reported during the compliance visit that the measures were of assessments completed within 30 days following the ISP annual planning meeting. Assessments completed following the meeting may be useful for providing services during the year but are not useful in establishing an integrated process of ISP planning that requires all IDT members to be informed of the health and behavioral status of each individual in advance of a planning session, and that encourages joint case formulation and collaborative service planning. Reporting percent of assessments completed 10 days ahead of planning meetings would be a valuable component of self-assessment. The Facility should determine means to assess whether planning of supports and services throughout the year involves IDT participation and review.

	Use of the data from Medical Provider Audits seems an appropriate way to assess whether physicians review recommendations from non-Facility clinicians but does not address whether there are other consultations that also require review. Furthermore, because the Audits are periodic, it does not provide sampling that may catch a lack of such documentation more routinely and timely, such as might be available from the recently-implemented consultation tracking process.
	Summary of Monitor's Assessment: The Facility had taken many steps toward providing clinical services in an integrated manner. Nevertheless, integrating planning and services across disciplines remained a challenge. Although Facility clinicians supported the need for integration, there were still not adequate processes in place to ensure it occurred. The Facility had taken positive steps, including consistent involvement of the PNMT nurse in ISP planning, and implementing shared caseloads for QDDPs and Nurse Case Managers. A morning medical meeting that involved physicians, QDDPs, and Nurse Case Managers provided an opportunity for integrated discussion about individuals and the potential to address systemic issues. There remained numerous examples in which there was not evidence of integrated services, including the absence of medical assessments and PBSPs from the ISP, assessments that did not show evidence of consideration of information from different disciplines, and lack of evidence of interdisciplinary involvement in plans to provide health and behavioral services. Facility clinicians documented review of consultation recommendations from non-Facility clinicians through initials and entries into the IPN. A new consultation tracking system had been implemented that should help to ensure consultations occur as ordered, and that reports are reviewed. Documentation of notice to the IDP for consideration was not evident.

#	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	The Facility had taken many steps toward providing clinical services in an integrated manner. Nevertheless, integrating planning and services across disciplines remained a challenge. The clinicians uniformly supported the need for integration. They still did not have adequate processes in place to ensure that the desired integration occurred. RGSC SOP ICF-MR 400-14 contained expectations for integration of medical care into the ISP. The QMRP is expected to invite the Primary Care Physician (PCP) to all PST/A (Addendum), Quarterly, and Special Staffings, and the PCP is expected to be an active	Noncompliance

#	Provision	Assessment of Status	Compliance
	receive the clinical services they need.	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 IDT as a whole. DADS had drafted a policy. It might be helpful if that policy added clarification on what would demonstrate integrated clinical services and provided examples. As reported in Provision F1b, the Monitoring Team reviewed ISPs and sign-in sheets for Individuals #26, #27, #55, #59, #63, #77, #84, #85, #88, and #139, and attended the ISP annual planning meeting and reviewed the sign-in sheet for Individual #97. Review of sign-in sheets indicated physicians did not attend most meetings, and the psychiatrist did not attend some meetings for individuals who are prescribed psychotropic medications. Neither was listed on the sign-in sheet for Individuals #27 and #55, the most recent individuals in each living unit to have ISPs developed and provided in the document request. Both the psychiatrist (on speakerphone) and PCP participated actively in the ISP meeting for Individual #97 held during this compliance visit, both were familiar with the individual, and they made helpful recommendations regarding needs and actions that were not specific to medical or psychiatric conditions. Provision F1b also states that the Facility responded to the comment noted in the last compliance visit report that Physical and Nutritional Management Plans (PNMPs) were not formally developed with input from the IDT, home staff, medical and nursing staff. One step taken by the Facility was to establish attendance by the PNMT nurse at all ISP annual planning meetings; sign in sheets for ISP annual planning meetings and observation during the compliance visit verified this attendance. Nevertheless, as reported in Provision O1, PNMPs were not clearly developed with input from all members of the IDT or reviewed consistently by the IDT. Required participation in IDT meetings is not limited to the ISP annual planning meetings but should occur as needed. One significant change in the organization of the Facility is reported to have increased integrated planning. Nurse Case Managers now share caseloads and office space with their respective QDDPs. In general, this has enhanced communication and collaboration regarding individuals on their mutual caseloads, leading to more integration of services with the respective QDDPs and Interdisciplinary Teams (IDTs). Observation of a morning medical meeting confirmed that this revised organization was in place and operating; at this meeting, the PCP also participated with the Nurse Case Managers and QDDPs. The morning medical meeting observed by the Monitoring Team focused on individuals but also showed potential for identification of systemic issues that need to be addressed.	

#	Provision	Assessment of Status	Compliance
		The Medical Doctor pointed out that a result of integrated planning has been a decrease in the use of medical restraint. Some clinical assessments included information showing review of assessments by other disciplines, but they did not indicate how the information affected the clinical findings or led to interventions that were coordinated to lead toward a similar goal. For example: • The Speech-Language evaluation for Individual #97 was 11 pages long and included a tremendous amount of information, but much of that did not relate it to communication (e.g., it included side effects of medications but did not comment on which side effects might affect communication; and it included description of the behavior support program that indicated function is sensory but also did not address the possibility of using communication strategy to indicate a desire to use the bathroom for toileting). The evaluation identified some nice strategies including use of a single-switch AAC device but did not identify objectives or data to be gathered. • PT/OT must integrate the diagnosis of osteoporosis in every action they recommend. PT/OT did not effectively integrate diagnosis into their assessments, or plan. The ISP must well represent this serious condition by documenting the current status of the condition, associated risks of treatment and no treatment, and necessary supports and services. • Acute Care Plans (ACPs) did not indicate they were developed in collaboration with other relevant disciplines. • Health Maintenance Plans (HMPs) did not document or indicate they were developed in collaboration with other relevant disciplines, with the exception for occasionally referring to other disciplines, e.g., PNMPs and/or PBSPs. • Psychiatric assessments did not integrate behavioral data when diagnosing, developing a case formulation, or deciding on medication management, and there was no indication of progress from the baseline site visit in the process of integrating psychological and psychiatric services. Other indications of lack of integrated planning included: • Documentation did not provide evidence that PNMPs and dining plans were formally developed with input from the IDT. • The Facility did not include medical assessments in any of the documentation that responded to document requests for assessments that supported ISPs. • Positive Behavior Support Plans and medical care plans were not included in ISPs; no action plans were developed for these. The Facility must continue to expand efforts to increase integration of services through integrated planning and review.	

#	Provision	Assessment of Status	Compliance
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 Medical and MBSS consultation reports for Individuals #3, #11, #19, #29, #51, #60, #69, #85, #86, #88, #91, #94, #97, and #118. The physician initialed all consultations except for one that had just arrived and was flagged for signature. All signed medical consultations had documentation of agreement; the Monitoring Team did not assess this for MBSS consultations. Of the 10 medical consultations, nine (90%) had been documented in the Integrated Progress Notes (IPN). Documentation was not provided by the Facility to show that recommendations of any of these consultations, medical or MBSS, were referred to the IDT. The Nursing Monthly Consultation Audit listed 16 Case numbers; date of physician order, consult scheduled, consult completed, consult report received, and Dr. reviewed finding; and comments (13 of the 14 comments referred to scheduling issues resulting in consult non-completion, with a consult ordered 5/20/11 not yet completed). The format of the audit should make it useful. It was not dated, but it appeared to cover consults that had been completed or were rescheduled in January 2012 including some ordered months before. Because only one month was provided, it was not possible to assess how it had been used, whether this audit had flagged consults that needed rescheduling and ensured they were not missed, or how else if might have been used. Certainly, it has the potential for value in ensuring consults occur as ordered and reports are reviewed. The Facility had made notable progress towards compliance in this area. To achieve compliance, the Facility should ensure that reviews of consultation include documentation of agreement, or lack of agreement with the consultants' recommendations, as well as documentation of notice to and (when appropriate) involvement of the IDT in responding to recommendations.	Noncompliance

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

1. Add to the draft DADS policy by specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring. (Provision G1)
2. Provide training, review and mentoring, or another process to assist clinicians to develop integrated case formulations and treatment recommendations and to develop documentation that clearly demonstrates this integration in PSPs and the active record. (Provision G1)
3. Ensure that reviews of consultation include documentation of agreement, or lack of agreement with the consultants' recommendations, as well as documentation of notice to and (when appropriate) involvement of the IDT in responding to recommendations.

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 Self-Assessment and Action Plan 2/13/12 2. RGSC Section G and H Presentation Book 3. DADS draft policy #005: Minimum and Integrated Clinical Services 1/12/10 4. RGSC SOP ICF-MR 400-14 Medical Care revised June 2011 5. PSPs, assessments, CLDPs, and other documents reviewed by members of the Monitoring Team, as identified in other sections of this report **People Interviewed:** 1. Group interview: David Moron, MD, John Partin, MD, Lorraine Hinrichs, ICF-DD Program Director, and Linda Lothringer, DADS **Meeting Attended/Observations:** 1. Morning Medical Meeting 3/1/12 2. Integrated Support Plan (ISP) annual planning meeting for Individual #97
	Facility Self-Assessment: The Facility reported compliance with Provision H2 and noncompliance with the remaining provisions. The Monitoring Team concurs. Nevertheless, the Monitoring Team found problems with activities and data on timeliness of assessments reported in the self-assessment. The self-assessment reported a high percentage of assessments to be completed timely. However, the Facility reported during the compliance visit that the measures were of assessments completed within 30 days following the ISP annual planning meeting. Assessments completed following the meeting may be useful for providing services during the year but are not useful in establishing an integrated process of ISP planning that requires all IDT members to be informed of the health and behavioral status of each individual in advance of a planning session, and that encourages joint case formulation and collaborative service planning. Reporting percent of assessments completed 10 days ahead of planning meetings would be a valuable component of self-assessment. Furthermore, the self-assessment did not report any process for determining whether assessments or evaluations are performed in response to developments or changes in an individual's status. The Facility also provided an Action Plan specifying activities to move toward compliance. Many of the activities had already been completed. The Action Plan did not provide a sequential set of activities based on analysis of what was not yet compliant and the gaps that remained, and that would build on each other to bridge those gaps. Instead, it was a set of activities that were individually important but were not comprehensive. Furthermore, some actions were probably relevant but did not contain the detail that would indicate how these actions would lead toward compliance nor how they would lead to other actions. For example, an action step for Provision H1 was to implement a QDDP peer review process; while this process would be likely to include review of whether assessments were completed, that was not stated in

	the Action plan, nor were there steps to build on that to ensure that the Facility would ensure assessments would be completed when due even if QDDPs flagged upcoming due dates or late reports. The fact that the Facility planned nearly or completely identical actions for nearly all provisions provided additional evidence that these activities were not based on a review of requirements and gaps, as some activities were relevant to some provisions but not others. For Provision H3, the self-assessment reviewed the presence of upper and lower control limits. However, change in health status may be qualitative rather than quantitative and may be abrupt; for example, a single injury may lead to a change in status requiring new assessments. Review of data trends if often useful in determining change of status (e.g., data on problematic behavior, blood pressure, sleep patterns) and decisions may appropriately consider control limits, but review of health status must also consider other information. For Provision H4, the only action for self-assessment was review of records to see if At-Risk Action Plans had been implemented. However, that is only tangentially related to the requirements of this provision. This provision requires that clinical indicators of efficacy of treatment of individuals be determined in a clinically justified manner. It also requires that there be clinical indicators of health status in the aggregate to assess that appropriate care is being provided.
	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. Although the Facility had, at the last compliance visit, reported it was in process of developing clinical indicators to be used in a system to monitor health status, there had not been progress in identifying and using clinical indicators. The Facility was in substantial compliance with the requirement that all diagnoses be consistent with current standards, and that they clinically fit diagnostic assessments.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with	Provision of assessments on both a regular basis and in response to change in health or behavioral status was not consistent across all disciplines. Although data provided by	Noncompliance

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	full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	the Facility showed most assessments completed, these data were based on assessments completed within 30 days following ISP annual planning meetings. It is important for the assessments to be completed prior to planning meetings to permit the IDT members to review assessments from other disciplines so they can have information needed for collaborative and integrated planning of services and supports. Furthermore, there were examples in which there was not evidence of assessment being done in response to changes in an individual's status. An overall facility plan was not in place to address provision H1 and ensure assessments were performed on a regular and timely basis, and were completed in response to changes in an individual's status. The Action Plan provided a list of activities; some involved completion of assessments, some (such as training on aspiration trigger sheets) involved information needed to show change in status that would require an assessment, and some (such as implementing a QDDP peer review process) did not provide adequate detail to make clear how they would improve completion of assessments. Provision F1c provided several examples in which assessments were not completed as needed: • As reported in Provision K6, although nearly everyone had an annual psychological assessment, information from the Facility indicated that as many as 56 individuals had not been provided an intellectual or adaptive assessment in the past year. • As reported in Provision M1, there had not been improvement in assessment of individuals with acute changes in health status. • As reported in Provision O2, individuals were not consistently 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. Some assessments did not provide comprehensive evaluation of essential issues: • The OT/PT assessment had sections that were meant to address 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 as well as comprehensive assessment intended to identify changes in status. • Medical issues and health risk indicators were not consistently included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions. • As reported in Provision P1, review of individuals with changes in status did not	

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		provide evidence of assessment or review as indicated by a change in the individual's status or as dictated by monitoring results. • As reported in Provision L1, for individuals with decline in neuromuscular-musculoskeletal function, there was not follow-up assessment for Individuals #15 and #140.	
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 that all psychiatric diagnoses reflected current Diagnostic and Statistic Manual (DSM) diagnosis, and did not include NOS, or rule out diagnosis. All medical diagnoses reflected current ICD diagnoses. The Facility complied with this requirement of Provision H2. The other requirement is that diagnoses shall clinically fit the corresponding assessments or evaluations. Medical and psychiatric diagnoses were noted to generally be consistent with diagnoses. The Monitoring Team had concerns that revolved primarily around a need for greater follow up to ensure adequate information for appropriate treatment. Although the Monitoring Team did have concerns about follow up as well as about further assessment to identify etiology of health care conditions, diagnoses were found to be consistent with assessment findings, and the Monitoring Team finds this provision to be in substantial compliance.	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.	The Facility had made some progress in specific areas of treatment. For example: • As reported in Provision K4, all sampled records included documentation of a monthly review of PBSP data. In addition, slightly over half of the records reviewed reflected that the PBSP had been reviewed or revised if three months had passed without demonstrable progress. Although this left roughly half the individuals lacking the necessary reviews and revisions, it reflected meaningful progress over baseline conditions. • As reported in Provision L1, physicians appropriately responded to acute conditions. Although many treatments and interventions were provided timely, there were instances in which they were delayed, did not have follow up to resolution, or were not changed when health or behavioral status changed. Furthermore, as identified in other Sections of this report, there were still gaps in completion of all required assessments, so treatments and interventions could not be based on those assessments. In addition, lack of comprehensiveness of assessment can make it difficult to select appropriate treatments and interventions. For example: • As reported in Provision L1, although there was appropriate initial management	Noncompliance

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		of acute medical conditions, follow-up evaluation through resolution of the condition by the physician was not consistent. • As reported in numerous individual examples in Provision L1, physicians appropriately responded to results of assessments but also found examples in which health issues were not reported in assessments, such as the lack of report of problems with gait for Individual #15. • As reported in Provision M3, there were examples of individuals for whom changes in health status should have required Acute Care Plans that were consistent with physician orders or nursing protocols and provided clear instructions about how the interventions were to be carried out, but that these were not always in place. • As reported in Provision O2, for individuals who experienced pneumonia or choking, there was not accurate identification of individuals who were at increased risk of physical and/or nutritional decline. • As reported in Provision K4 for Individual #134, data showed a PBSP to be effective at changing one behavior but not another target behavior, yet the PBSP continued without revision.	
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.	<u>Clinical Indicators of Individual Care</u> The Medical Director stated they continue to use standard clinical indicators for evaluating status of conditions for individuals. There have not been changes in such clinical indicators, and the Facility did not report any guidance on clinical indicators from clinical pathways that are being developed. Clinical indicators of efficacy are important outside, as well as within, the medical discipline. There was not yet broad use of clinical indicators of efficacy. • As reported in Provision O7 for a sample of 18 individual records, the PNM Team or IDT 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 individuals with the most complex physical and nutritional support needs. While PNMPs are reviewed at the annual ISP, there was not a system fully in place that clearly monitored the effectiveness of the plan by tracking clinical indicators for all individuals who were 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 J13, no sampled psychiatric treatment plans ensured that the IDT understood the monitoring criteria (that is, clinical indicators of individual status) to assess efficacy. • As reported in Provision I3, risk plans did not document the clinical indicators to	Noncompliance

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		be monitored for effectiveness of risk action plans. <u>Status of Facility Health Care</u> The Facility had not developed a functional and accurate management system to provide clinical data. The development of such a system to aggregate clinical data and flag emerging issues will be needed. The Medical Director reported that development of clinical indicators to assess status of health care was in early stages.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The Facility had not developed a process to conduct quality assurance review to assess the Facility's overall management of medical care. The Facility reported that they will begin developing a QA process in the near future. Although the physicians monitored clinical indicators of care for individuals, there were no established indicators of health status for the Facility, such as tracking indicators of diabetes, changes in range of motion for people with spasticity, or changes in frequency of seizures; development of such indicators was reported to be in early stages. A risk assessment process had been implemented but still did not fully result in accurate rating of risk nor in identifying frequency of monitoring based on level of risk. Nevertheless, staff reported that it assisted them to review health status in a more integrated manner. As reported in Provision I3, risk plans did not include clinical indicators for monitoring health status. The morning medical meeting that involves physicians, nurse case managers, QDDPs, and other clinicians provides an opportunity to discuss hospitalizations and returns, calls received during on-call times, and any other medical or health status issues that are of concern. A policy/protocol does not exist at RGSC that addresses the health status monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. Such a process should include clinical indicators and should involve reporting of resolution of acute conditions and measure or improvement or decline in people with chronic health conditions.	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The Facility did not have clear guidance on the use of clinical indicators or on when treatments and interventions should be modified. In the medical arena, DADS is working on selecting or developing clinical pathways, which should include such guidance. Risk Action Plans did not consistently include measureable, observable, and realistic objectives for each action step to evaluate the effectiveness of the plan. Clinical	Noncompliance

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		indicators were not consistently included for each risk rating. The plans failed to include action steps for all relevant disciplines. Provision L1 provides several examples in which there was continuing deterioration in health status (for example, in gait) but no continuing tracking of status. As reported in Provision K4, data were not reported for replacement behaviors. Thus, there was no way to determine whether a teaching procedure was functional and whether the PBSP needed revision (or, when there was no reduction in target behavior, whether the replacement behavior needed to be revised).	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The Facility policy governing common elements of clinical care was RGSC SOC ICF-MR 400-14. Although it includes information about integration of services, it did not provide extensive information about clinical policies and procedures. Furthermore, DADS policy remained in draft. A draft DADS state policy was available and this was an improvement since the last onsite review. It addressed provisions G and H together. The policy was not yet completed or disseminated. The majority of the policy addressed section H and appeared to be a good start to providing the Facility with some guidance and direction. It might be helpful to indicate how the contents of the policy related to each of the specific seven provision items of Section H. For provision item H1, the policy listed some details about the regulatory or statutory requirements for a nursing quarterly review, an annual dental exam, a review of behavior control drugs, an annual physical, and a review of risk status. There was nothing in the policy, however, regarding assessments and evaluations for psychiatry, psychology, pharmacy, physical therapy, speech and language therapy, dietary needs, occupational therapy, and respiratory therapy (in this policy, DADS added respiratory to the list of clinical services). To achieve compliance, both the Facility and DADS will need to ensure policies that address the requirements of this Section are established and monitored for accurate implementation.	Noncompliance

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

1. Develop a process to track assessments, diagnoses, and diagnostic updates to ensure assessments are done both regularly and in response to changes in an individual's status (Provision H1)
2. Ensure all required assessments are completed and posted to the Share Drive in time to permit review by IDT members. (Provision H1)
3. Develop a system to identify, track, and aggregate clinical indicators and flag emerging issues. (Provision H4)
4. Develop a system to monitor health status of individuals; such a system should include clinical indicators and should include reporting of resolution

of acute conditions and measures of improvement or decline in chronic conditions. (Provision H5)

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 Self-Assessment and Action Plan 2/13/12 2. RGSC Section I Presentation Book 3. RGSC SOP MR 400-02 At Risk Individuals revised 2/11 4. DADS At Risk Policy 6.2 updated 2/18/11 5. Records for Individuals #29, #33, #46, #76, #80, #97, and #134 P**eople Interviewed:** 1. Lorraine Hinrichs, ICF-MR Program Director and Section I Lead **Meeting Attended/Observations:** 1. Incident Management Review Team (IMRT) 2/26/12 2. Settlement Agreement Performance Improvement Council (SA-PIC) 2/29/12 3. Individual Support Plan (ISP) annual planning meeting for Individual #97
	Facility Self-Assessment: The RGSC Self-Assessment reported it had conducted a review of the RGSC At Risk Policy to determine if the policy had been fully operationalized and that the Facility had monitored policy implementation using the Section I Monitoring Tool. The Facility reported in its Self-Assessment that full implementation of policies was not in place. In the two records reviewed using the monitoring tool compliance rates were 17% and 27%. The RGSC Self-Assessment reported that all three provisions in this section of the SA were not in substantial compliance. . The activities and results of the Facility's self-assessment were general and not sufficiently directed at the specific requirements of each provision. The Facility will need to ensure that future self-assessments target each specific requirement of each provision of the SA.
	Summary of Monitors Assessment: Progress in complying with this section of the SA was characterized as "slow" by RGSC administrative staff. Evidence reviewed by the Monitoring Team confirmed this. Little substantive progress, until very recently, had occurred in meeting the requirements of this section of the SA. Responsibility for Section I had been assigned to the ICF Program Director who had recently initiated an administrative process that when fully and effectively implemented should lead to improved compliance. This process had been put in place just prior to this monitoring visit and at the time of the review would best be characterized as a conceptual design that would ensure risk related assessments occur timely, are coordinated between disciplines, and result in appropriate risk action plans. Effective implementation will depend on sound judgment from the various clinicians that conduct discipline related assessments and the action plans designed to mitigate risk. The Monitoring Team looks forward to assessing implementation at the next review.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The RGSC reported in its self-assessment that it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The RGSC self-assessment reported it had engaged in the following activities in conducting its self-assessment: 1. Conducted a review of the RGSC At Risk Policy to determine if it had been operationalized. 2. Monitored the At Risk processes using the Section I Monitoring Tool. These were completed by the ICF Program Director and QE Nurse to determine compliance with RGSC policy. The results of the RGSC self-assessment were: 1. The review of policy showed full implementation of operationalized policies was not in place at RGSC. 2. Two records were reviewed utilizing the DADS State Office Section I Monitoring Tool. Compliance with At Risk process were: 10/2011 = 17% 01/2012 = 27% The RGSC self-assessment reported that based on the findings from this self-assessment, this provision was not in substantial compliance because At Risk processes were not fully implemented as evidenced by Section I monitoring scores. Responsibility for Section I had been assigned to the ICF Program Director who had recently initiated an administrative process that when fully and effectively implemented should lead to improved compliance. This process had been put in place just prior to this monitoring visit and at the time of the review would best be characterized as a conceptual design that would ensure risk related assessments occur timely, are coordinated between disciplines, and result in appropriate risk action plans. Effective implementation will depend on sound judgment from the various clinicians that conduct discipline related assessments and the action plans designed to mitigate risk. The Monitoring Team looks forward to assessing implementation at the next review. The Monitoring Team reviewed the risk assessment planning associated with six individuals. In five of six instances evidence supported that the assessment was inadequate to determine risk level. For example: • Individual #29's risk status was discussed at a PNMT meeting; however changes in the individual's risk conditions were not reflected in the outcome of the meeting. • Individual #97 did not have a diagnosis of diabetes but was taking an atypical antipsychotic medication with the potential to cause hyperglycemia and was	Noncompliance

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		having blood glucose levels evaluated every six months. The potential for developing hyperglycemia with the required routine blood sugar level evaluation should have elevated the risk level for diabetes to at least a medium risk. The findings of the Monitoring Team were consistent with the findings of the RGSC monitoring referenced above. Clinicians at RGSC were not 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 ISP meeting that was held during the week of the review. Review of risks was spread throughout the discussion, so that risks were discussed when relevant to the specific topic being addressed; for risk areas that were not otherwise discussed, the QDDP specifically raised the areas for discussion. Throughout the discussion the team members made corrections and additions to the draft Risk Screening Assessment risk level ratings and respective rationales, as well as from the previous risk level ratings. The active medical record was referred to during the meeting to clarify clinical issues. Risk level ratings were changed appropriately based on discussion and clinical data supporting the change in levels, with the exception of a low risk rating for diabetes. While Individual #97 did not have a diagnosis of diabetes, the individual was taking an atypical antipsychotic medication with the potential to cause hyperglycemia and was having blood glucose levels evaluated every six months. The potential for developing hyperglycemia with the required routine blood sugar level evaluation should have elevated the risk level for diabetes to at least a medium risk. The related Risk Action Plan was not completed at the time of the meeting. Staff present at the ISP included the actual staff who worked with the individual. The individual was present but did not participate. The family was unable to attend. Although some risks were clearly discussed in terms of how they would affect planning (e.g., identifying the supports that would be needed to address behavioral issues both at the Facility and in considering referral to a more integrated setting), it was not clear how most ratings would be integrated into the ISP process. The completed ISP was not provided to the Monitoring Team by the time of this report, and therefore it was not possible to review the final risk ratings or actions to address risks. RGSC was also deficient in adequately responding to individuals who had a change in health status that should have resulted in risk screening. Referring to Section O of this report it is noted that none of the five Individuals with physical/nutritional management issues reviewed by the Monitoring Team underwent a risk assessment screening after a	

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		change in health status.	
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 self-assessment that it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The RGSC self-assessment reported that based on the findings from this self-assessment, this provision was not in substantial compliance because At Risk processes were not fully implemented as evidenced by Section I monitoring scores. The activities and results of the Facility's self-assessment for this Provision were not directed at the specific requirements of this provision. They were a restatement of the self-assessment activities and results described in I.1 above. The Monitoring Team reviewed the records of six individuals to determine if appropriate risk assessment activity had taken place and was documented. These included Individuals #33, #46, #76, #80, #97, and #134. There was only one instance, Individual #97, of clear documentation that the IDT started the assessment process as soon as possible but within five working days of the individual being identified as at risk. With other individuals, comprehensive risk assessment documentation was not evident, for example Individuals #33, #46, #76, and #134. The records of these six 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 IDT 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 individual, Individual #97. Based on a review of records of three individuals (Individuals #33, #80, and #134) for whom assessments had been completed to address the individuals' at risk conditions, one (Individual #80) included an adequate nursing assessment to assist the team in developing an appropriate plan. The following provides examples of inadequacies in the assessment process: • Individual #33 had numerous changes from low and medium risks and from medium to high. There was no Risk Action Plan developed or available for review to address the changes. The Personal Support Plan Addendum (PSPA) was not updated to reflect changes in risk ratings. • For Individual #134 a Risk Action Plan was not available for review nor was it updated in PSPA. Other examples of deficiencies in risk screening and assessment processes include:	Noncompliance

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		Referring to Sample #1 in Section O of this report, only one of five (20%) individuals who were diagnosed with a physical/nutritional management issue was assessed or comprehensively reviewed by the Physical Nutritional Management Team (PNMT) or IDT. For example: • Individual #76 was diagnosed with pneumonia on 12/17/11 but there was no evidence of comprehensive assessment or review by the PNMT or IDT. PNMT minutes stated that there may be a need for a swallow study due to the fact that it may be aspiration. Once the study was completed, the PNMT had a brief statement stating to keep the individual on a regular diet. No further investigation occurred. • Morning meeting minutes 12/19/11 recommended a special staffing for both Individual #46 and #76 but there was no evidence that this occurred. • Individual #108 was diagnosed with pneumonia on 1/6/12 but there was no evidence of reassessment or discussion of the event by the IDT or PNMT.	
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 RGSC reported in its self-assessment that it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The RGSC self-assessment reported that based on the findings from this self-assessment, this provision was not in substantial compliance because At Risk Processes were not fully implemented as evidenced by Section I monitoring scores. The activities and results of the Facility's self- assessment for this Provision were not directed at the specific requirements of this provision. They were a restatement of the self-assessment activities and results described in I.1 above. The Monitoring Team reviewed the records of six individuals to determine if appropriate risk assessment activity had taken place and was documented. These included Individuals #33, #46, #76, #80, #97, and #134. 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 none of the six cases. • Implemented a plan within 14 days that met the needs identified by the IDT assessment in none of the six cases. • Included preventative interventions in the plan to minimize the condition of risk in none of the six cases. • Of two cases in which the risk to the individual warranted, the Facility took immediate action in neither. • Integrated the plans into the ISPs in none of the six cases.	Noncompliance

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		• None of the risk plans documented adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. • None documented appropriate functional and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. • None documented the clinical indicators to be monitored and the frequency of monitoring. Additional observations involving Physical and Nutritional Management and related to this component of the SA found 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 and consistent delivery of service. This included lack of staff positioning, adaptive equipment and information regarding texture or consistency of liquids or medications. This demonstrates a lack of comprehensiveness of the plan and lack of integration between all appropriate disciplines.	

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

1. The Facility should assure all IDTs are provided with training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the new ISP 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 ISP process (Provisions I.1, I.2, and I.3).
2. Ensure that appropriate and timely assessment and revision of the ISP is done for any individual whose level of risk is revised as the At-Risk Individuals policy is implemented (Provisions I.1, I.2, and I.3).

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 Self-Assessment and Action Plan 2/13/12 2. RGSC Section J Presentation Book 3. RGSC Standard Operating Procedure, ICF-MR 400-13, dated December 3, 2010 4. Appendix B of the Settlement Agreement 5. CME records and CPR certification for Facility psychiatrists 6. Psychiatric annual and psychiatric quarterly medication reviews for Individuals #33, #139, #149, #133, and #46 7. Most recent psychotropic medication orders for Individuals #33, #139, #149, #133, and #46 8. All psychiatric assessments for the past six months for Individuals #58, #115, #46, #40, #3, #134, #94, #4, and #80 9. Most recent psychiatric evaluations for Individuals #140, #139, #84, #3, #66, #2, #54, #134, and #40 10. P&TC minutes for February 2012 11. Reiss Screen for Individuals #127, and #46 12. Current consent form and proposed updated consent form **People Interviewed:** 1. David Moron, MD – Treating Psychiatrist, and Clinical Director **Meeting Attended/Observations:** 1. Observations of Individuals #33, #139, #149, #133, and #46
	Facility Self-Assessment: The Facility reported that it was compliant with Provisions J1, J2, J3, J6, J7, and J8. The Monitoring Team concurs with the Facility's Self-Assessment of substantial compliance for Provisions J1, J6, and J7 but disagrees with the Facility's Self-Assessment for Provisions J2, J3, and J8. Specific to Provision J2, the Facility reported that a psychiatrist assesses all Individuals prior to initiating psychotropic medications, and the Monitoring Team concurs with this finding; however, the assessments lack integration of behavioral data. It is imperative that behavioral data is integrated into the treatment plan, prior to initiating psychotropic medications. Regarding Provision J8, the Facility reported that a psychiatrist meets quarterly or more often as deemed necessary during the psychotropic medication reviews, and that such effort satisfies the requirement of the Provision to ensure that pharmacological treatments are integrated with behavioral and other interventions through a combined assessment and case formulation. The Monitoring Team reviewed psychiatric assessments and determined that the Facility does not consider behavioral interventions or behavioral data when deciding upon pharmacological treatments. The Facility determined itself to be noncompliant with Provisions J4, J5, and J9 through J15, and the

	Monitoring Team concurs with this assessment. The Monitoring Team is especially concerned with the Facility's self-assessment for Provision J15, as it does not address the provision. Provision J15 requires that the psychiatrist and neurologist collaborate on cases that antiepileptic drugs are being proscribed for both neurological and psychiatric conditions.
	Summary of Monitor's Assessment: Provision J1: Because the treating psychiatrist is appropriately trained in general psychiatry, and maintains appropriate level of CME training, the Monitoring Team determined that the Facility continues to be substantially compliant with Provision J1. Provision J2: The quality of psychiatric evaluations are of very high quality. All evaluations reviewed were done by a board-certified psychiatrist. This provision was found in substantial compliance. Provision J3: The Monitoring Team concluded that the Facility administers psychotropic medications in accordance with Provision J.3, but did not provide adequate information about behavioral treatment programs to conclude that there were effective behavioral programs that might complement the use of medication intervention. and determined that the Facility is not in compliance. Provision J4: Because the Facility does not have a process to evaluate the need for pre-treatment sedation, the Monitoring Team determined that the Facility remains not in compliance with Provision J4. Provision J5: Because of significant staff shortage in psychiatric services, the Facility is not compliant with Provision J.5. Compliance will require additional psychiatric support. Provision J6: The Monitoring Team determined that the psychiatric evaluations reviewed meet many,b ut not all, the requirements in Appendix B. Behavioral data were not yet included in the evaluation and case formulation, and the inclusion of a bio-psycho-social-spiritual formulation was recent. The provision is not yet in substantial compliance. Provision J7: The Monitoring Team determined that the Facility continues to be in substantial compliance with Provision J7. All newly admitted individuals were provided a Reiss Screen, which was well incorporated into their psychiatric assessment. Provision J8: Because the Facility did not include behavior data analysis when considering medication management, and does not routinely assess for alternative therapies to medications, the Monitoring Team continues to find the Facility not in compliance with Provision J.8. Provision J9: The Monitoring Team determined that the Facility did not have a process whereby the psychiatrist participates in an IDT meeting, along with the psychologist, to determine the least intrusive and most positive interventions to treat behavioral or psychiatric conditions, or to ensure that alternative treatments, such as combined pharmacological and behavior, or just behavior interventions are entertained when developing treatment plans. For these reasons the Facility remains not in compliance

	with Provision J9. Provision J10: Because a psychiatrist, primary care physician, psychologist and nurse did not regularly participate at IDT 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. Provision J11: Because the Facility does not meet regularly to assess and report on Individual or Facility wide use of polypharmacy, and does not conduct trends analysis with appropriate action plans to reduce polypharmacy, the Monitoring Team determined that the Facility remains not in compliance with Provision J11. Provision J12: The documents requested to review Provision J12, were not provided, so the Monitoring Team used MOSES and DISCUS samples provided in document request TX-RG 1203-RC28. This resulted in a smaller sample size. The Monitoring team noted that assessments were not completed timely in three of the five samples (60%); were not consistently completed by the physician in three of the five samples (60%); lacked documentation about important abnormal findings in five of the five samples (100%); and the MOSES did not reflected abnormal findings on the MOSES in two, of the five samples (40%). For these reasons the Monitoring Team determined that the Facility was not in compliance with Provision J12. Provision J13: The Monitoring Team concluded that the Facility remains not in compliance with Provision J13 because it does not ensure that expected timelines for therapeutic effects, and a listing of who, what, and how often to monitor for treatment efficacy, was clearly delineated in the treatment plan, and known to the IDT. Provision J14: Because the Facility did not have a process to evaluate the need for pre-treatment sedation, the Monitoring Team determined that the Facility remains not in compliance with Provision J4. Provision J15: Because the Facility did not have a functional procedure and practice that ensures collaboration between neurology and psychiatry, for those individuals who are prescribed medication to treat both psychiatric and neurologic conditions, the Monitoring Team determined that the Facility remains out of compliance with Provision J15.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	The Facility's psychiatrist is board certified in general psychiatry, and completed 24.75 Continuing Medical Education (CME) hours in 2011. Five hours of CME included training on challenging behaviors. The psychiatrist maintains current certification in Healthcare Provider CPR. Because the treating psychiatrist is appropriately trained in general psychiatry, and	Substantial Compliance

		maintains appropriate level of CME training, the Monitoring Team determined that the Facility continues to be substantially compliant with Provision J1.	
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.	To assess the Facility's ability to ensure that all individuals who are treated with psychotropic medications have been appropriately evaluated, the Monitoring Team reviewed the most recent psychiatric annual and psychiatric quarterly medication reviews for Individuals #33, #139, #149, #133, and #46. The Monitoring Team noted that for five out of five (100%), all diagnoses reflect current Diagnostic and Statistic Manual (DSM) diagnosis, and did not include NOS, or rule out diagnosis. The psychiatric assessments reflected a review of medications, side effects, MOSES and DISCUS assessments, medical history, mental status examination and case formulation in five out of five (100%) cases reviewed. Five out of five (100%) of the assessments were completed by a board certified psychiatrist. Conclusion: The quality of psychiatric evaluations is of very high quality, and all individuals receiving psychotropic medications have been evaluated and diagnosed by a board certified practitioner. As noted in Provision J6, many requirements of Appendix B are covered in the psychiatric evaluations, and progress is being made on completing those. It should be noted that the Facility reported that they would immediately begin collaboration with psychology services and begin the inclusion of behavior data into the evaluations.	Substantial Compliance
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 recent adjustments for psychotropic medications, and review of the clinical records of individuals #33, #139, #149, #133, and #46, and review of the most recent P&TC minutes for STAT psychotropic medications, the Monitoring Team identified that five out of five (100%) individuals were provided psychotropic medications appropriately in response to psychiatric diagnosis and not as a substitute for behavioral therapy, staff convenience, or punishment. Nevertheless, the Facility did not provide adequate information about the presence of effective positive behavior support programs or other interventions; therefore, the Monitoring Team could not determine that psychotropic medication was not a substitute for behavioral therapy. Conclusion: The Monitoring Team concluded that the Facility administers psychotropic medications appropriately for psychiatric diagnoses and not for staff convenience or punishment but could not conclude that there were effective behavioral programs that might complement the use of medication intervention.	Noncompliance
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18	The Monitoring Team did not review clinical data to determine if the Facility ensures that all pre-treatment sedation for routine medical or dental care is systematically assessed for less restrictive forms of treatment. The Clinical Director, Dr. Moron, informed the	Noncompliance

	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.	Monitoring Team that because of his current workload, he was not able to address the requirements of the Provision, and the Facility has made no progress since the last review. Conclusion: Because the Facility did not have a process to evaluate the need for pre-treatment sedation, the Monitoring Team determined that the Facility remains not in compliance with Provision J4.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	To determine if the Facility had adequate psychiatric services to support the psychiatric needs of individuals served by the Facility, the Monitoring Team conducted an interview to discuss psychiatric services with the Facility's Clinical Director, who also serves as the Facility's psychiatrist. Dr. Moron informed the Monitoring Team that since its last review, the Facility lost an FTE psychiatrist, leaving only Dr. Moron, to serve as the sole psychiatrist as well as Clinical Director. Importantly, Dr. Moron, only provides a 0.5 FTE position, and has responsibilities elsewhere. Dr. Moron reports having difficulties keeping up with his case load, attending to daily administrative responsibilities, while attempting to develop corrective measures for the psychiatric component of the Settlement Agreement (SA). It was clear to the Monitoring Team that because of Dr. Moron's schedule, regardless of his ability and dedication, which is exemplary, there has been lack of progress towards compliance with the SA, and failure to ensure that psychiatric services are provided in accordance with the SA. The Facility reported it has continued to recruit for a qualified applicant to fill this position. Conclusion: Because of significant staff shortage in psychiatric services, the Facility is not compliant with Provision J.5. Compliance will require additional psychiatric support.	Noncompliance
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,	Per interview with the Clinical Director, Dr. Moron, all individuals who had a psychiatric diagnosis, including all individuals on psychotropic medications, (100%) at the Facility had been reassessed using Appendix B criteria. Provision J6 requires that the Facility develop and implement specific procedures to ensure that psychiatric assessment, diagnosis, and case formulation are consistent with generally accepted professional standards of care, as delineated in Appendix B. To assess compliance, the Monitoring	Noncompliance

	and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	Team reviewed the 9 most recent Psychiatric Evaluations (Individuals #58, #115, #46, #40, #3, #134, #94, #4, #80). The Psychiatric evaluations reviewed by the Monitoring Team were complete and comprehensive. Eight out of 9 (89%) included a bio-psycho-social-spiritual formulation, and 9 out of 9 (100%) met the remaining criteria as delineated in appendix B, of the Settlement Agreement. The Monitoring Team was informed that inclusion of a bio-psycho-social-spiritual assessment just recently started to occur on a regular basis, but the sample extended back to before the last compliance visit. Psychiatric evaluations were completed timely in 9, out of 9 occasions (100%). No NOS diagnoses were found. All comprehensive psychiatric evaluations described the symptoms following DSM criteria for the diagnosis. Each psychiatric evaluation was accompanied by a thorough medication history. Case formulation was clear and explicit. However, psychiatric assessments did not integrate behavioral data when diagnosing, developing a case formulation, or deciding on medication management, representing zero out of five (0%) that provided an integrated assessment. It should be noted that the Facility reported that they would immediately begin collaboration with psychology services and begin the inclusion of behavior data into the evaluations. Conclusion: The Monitoring Team determined that the psychiatric evaluations reviewed meet most of the requirements for Provision J.6 but lacked integration of behavioral data, and had only recently included a bio-psycho-social-spiritual formulation. Although much progress has been made, the requirements of Appendix B were not fully met, and the Facility in not yet in substantial compliance. The Monitoring Team would like to remind that Facility to continue to enhance the bio-psycho-social-spiritual aspect of the assessment and to integrate behavioral data into case formulation.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment	At the time of the Monitoring Teams last review, evidence was provided demonstrating that all individuals had been evaluated by a Reiss Screen. Since the last compliance visit, two individuals were admitted to the Facility (Individuals #127, and #46). The Monitoring Team verified that both individuals were provided a Reiss Screen assessment, which was incorporated into their psychiatric assessment, representing 2, out of 2 (100%) admissions. Any individual who had a positive finding on the Reiss Screen also had a comprehensive psychiatric evaluation (100%) All individuals at the Facility who had a psychiatric diagnosis have had a psychiatric assessment and update.	Substantial Compliance

	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.	Conclusion: The Monitoring Team determined that the Facility continues to be in substantial compliance with Provision J7. All newly admitted Individuals were provided a Reiss Screen, which was well incorporated into their psychiatric assessment.	
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.	At the last Monitoring Team review, psychiatric assessments, and medication evaluations were reviewed for Individuals #140, #139, #84, #3, #66, #2, #54, #134, and #40, and following that review it was determined that the Facility did not include behavior data analysis when making medication changes, nor did it assess for non-medication alternative treatments. During the current review, the Monitoring Team was informed by the Clinical Director, who is also the practicing psychiatrist at the Facility, that the Facility had not developed a process to include behavior data into the evaluation process for psychiatric evaluations, nor did it routinely assess for non-medication alternatives to treatment. The Monitoring Team reviewed the psychiatric assessments and evaluations for Individuals #58, #115, #46, #40, #3, #134, #94, #4, #80, #33, #139, #149, #133, and #46 and found that zero out of 14 (0%) of the assessments reviewed included analysis and incorporation of behavior data, when determining medication changes, and zero out of 14 (0%) included assessment for alternative treatments to psychotropic medications. The Monitoring Team is aware that the psychiatry and psychology departments will be meeting in the near future to develop a meaningful process that ensures the inclusion of behavior data into all psychiatric assessments. By review of the psychiatric evaluations for Individuals #58, #115, #46, #40, #3, #134, #94, #4, and #80, the Monitoring Team determined that psychiatric treatment plans were not developed in concert with the psychologist and were not integrated into combined pharmacological and behavioral treatment plan. This fact was corroborated by the treating psychiatrist, Dr. Moron. Conclusion: Because the Facility does not include behavior data analysis when considering medication management, and does not routinely assess for alternative therapies to medications. Importantly, the Monitoring Team determined that psychiatric treatment plans were not developed in concert with the psychologist and are not integrated into combined pharmacological and behavioral treatment plan. The Monitoring team continues to find the Facility not in compliance with Provision J.8.	Noncompliance

J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	The Monitoring Team met with the Clinical Director to determine the Facility's progress in developing a plan to ensure that psychiatrists would participate at IDT meetings that were involved in the development of least intrusive and most positive psychiatric and behavior intervention programs. The Clinical Director informed the Monitoring Team that the Facility has made no progress in this area, but will be meeting with the psychology department in the near future to begin working on a specific procedure to address this issue. The Monitoring Team reviewed the psychiatric assessments, and medication evaluations for Individuals #58, #115, #46, #40, #3, #134, #94, #4, #80, #33, #139, #149, #133, and #46, and determined that in zero out of 14 examples (0%), did the Facility ensure that least intrusive and most positive intervention plan was developed. There was no evidence to support collaborative efforts among the psychiatrist and psychologist to develop least intrusive and positive support plans. Conclusion: The Monitoring Team determined that the Facility did not have a process whereby the psychiatrist participates in a IDT meeting, along with the psychologist, to determine the least intrusive and most positive interventions to treat behavioral or psychiatric conditions, or to ensure that alternative treatments, such as combined pharmacological and behavior, or just behavior interventions are entertained when developing treatment plans. Compliance will require that a formal process be developed to ensure that the required professionals participate at specific IDTs when developing Positive Behavioral Support Plans.	Noncompliance
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 Clinical Director informed the Monitoring Team that there has been no improvement with the development of a comprehensive IDT process that includes the psychiatrist, nurse, primary care physician, psychologist, and other relevant staff to ensure appropriateness of treatments. 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 IDT 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 IDT meetings to determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medications. Furthermore, as reported in Section F, the psychiatrist was often not listed as a participant at ISP annual planning meetings for individuals who are prescribed psychotropic medications, including polypharmacy.	Noncompliance

		Conclusion: Because a psychiatrist, primary care physician, psychologist and nurse did not regularly participate at IDT 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.	
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.	Unable to complete – doc request not provided The Monitoring Team was informed by the Facility that the Polypharmacy Subgroup meetings are attended by a physician; however, the Facility could not produce documentation to support that the committee reviewed individuals who were on polypharmacy on a monthly basis. Review of the Polypharmacy Workgroup Committee Meeting Minutes indicated that the last polypharmacy meeting met on October 24, 2011. Documentation provided for this review indicated that the Facility's polypharmacy committee had not met since October 24, 2011. Therefore, there was no ongoing facility-wide review of clinical appropriateness of use of polypharmacy, no review of trends in usage, and no planning to identify and reduce unnecessary use of polypharmacy. Review of the Facility's Polypharmacy Workgroup Minutes, dated 8/8/11, and 8/24/11, indicated that the Facility reviews a predetermined number of individuals who were identified as being on polypharmacy. Not all individuals on polypharmacy are reviewed monthly. In addition, the Facility did not have a process to evaluate polypharmacy system-wide by means of trends analysis. The Facility continued to utilize significant polypharmacy. For example, at the time of this review, a total of 19, out of 72 individuals (26%), were prescribed two or more antipsychotic medications, which is considered to be significant polypharmacy by generally accepted standard of care for Individuals with Developmental Disabilities. The Facility must enhance its effort to monitor the use of polypharmacy. Pharmacy must not only collect data, it must analyze the data for trends and provide a meaningful summary, along with clinical recommendations for the pharmacy and therapeutic committee to review. The P&T committee must carefully assess the Facility's use of polypharmacy, and make systematic, as well as individual recommendations. All recommendations must be track for efficacy and completeness. Conclusions: Because the Facility does not meet regularly to assess and report on Individual or Facility wide use of polypharmacy, and does not conduct trends analysis with appropriate action	Noncompliance

		plans to reduce polypharmacy, the Monitoring Team determined that the Facility remains not in compliance with Provision J11.	
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 clinical data, which included the most two recent MOSES and DISCUS for ten individuals (TX-RG 1203-RC.24); however, no MOSES or DISCUS were included in the information provided, therefore, the Monitoring Team used MOSES and DISCUS assessments included in document request TX-RG 1203-RC28, which included MOSES and DISCUS assessments for only five Individuals #65, #56, #26, #96, and #48. The Monitoring Team did not find significant problems with timeliness, completeness and appropriateness of the sample reviewed but the Facility did not provide a large enough sample (that is, all the documents requested) to permit the Monitoring Team to assess this adequately. Individual #65: On 6/15/11, the DISCUS score was 0, and the physician indicated no tardive dyskinesia (TD). On 9/11/11, the DISCUS score was 3, and the physician, who reviewed the assessment 2 ½ Months after the assessment was completed by the nurse, indicated probable TD, and did not explain the change on the comment section of the assessment. Importantly, more frequent monitoring was not performed. The DISCUS assessment completed on 12/6/11 had a score of 2, and the physician indicated probable TD, but no comments were documented on what action steps should be taken. The Monitoring Team found it positive that when it compared the abnormal findings between the DISCUS and MOSES assessments, which were completed on 9/11/11, they corroborated each other. Individual #56: The physician did not complete his section of the MOSES dated 9/6/11 and 12/13/10, and MOSES assessments were not completed timely. Individual #26: The MOSES dated 7/16/11 indicated on item #33 of the assessment an abnormal gait. The physician who signed the assessment did not complete his component of the assessment, nor did he comment on this potentially serious abnormality. The MOSES dated 1/17/12 did not document an abnormal gait. The physician did sign and complete his component of the assessment, but again, did not document the changes noted from the previous MOSES. Individual #96: The DISCUS dated 3/26/11 documented that the individual was on a total dose of 160	Noncompliance

		mg of Geodon per day, in divided doses, which is a significantly high dose. The assessment indicated that there was facial grimacing at a level of 1, and tongue thrusts at a level of 2. The report indicated a total score of 2, when in fact, the total score should have been 3. The physician indicated that the individual had persistent TD. On 6/25/11, the total score for TD was increased to 4, and the physician indicated that the individual had probable TD and there was no further comment specifying an action plan for the worsening TD. Despite having abnormal movements and being on a significant dose of Geodon, there were no additional assessments provided. The most recent DISCUS dated 12/16/11, was two months late, and continued to indicated a TD score of 4. The MOSES assessments dated 6/25/11, and 12/16/11, both Indicated abnormal movements; however, the physician indicated no action necessary and did not comment on the abnormal findings. Individual #48: DISCUS assessments dated 2/1/11, and 6/21/11 indicated no TD and a assessment score of 0. Discus dated 9/17/11 indicated that the Individual was now grimacing and had an assessment score of 1, and the physician did not comment on this change, and no increase in the frequency of monitoring was provided, if fact the follow-up DISCUS assessment was not completed until 5 Months later, instead of quarterly. The physician did not complete the physician component on the MOSES dated 8/3/11, and on the MOSES dated 2/9/12, there was no indicated about the grimacing movements noted on the DISCUS assessments dated 9/17/11 and 2/6/11. Conclusion: The documents requested to review Provision J12, were not provided, so the Monitoring Team used MOSES and DISCUS samples provided in document request TX-RG 1203-RC28. This resulted in a smaller sample size. The Monitoring team noted that assessments were not completed timely in three of the five samples (60%); were not consistently completed by the physician in three of the five samples (60%); lacked documentation about important abnormal findings in five of the five samples (100%); and the MOSES did not reflect abnormal findings on the MOSES in two, of the five samples (40%). For these reasons the Monitoring Team determined that the Facility was not in compliance with Provision J12.	
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	To assess if treatment plans were reviewed through the IDT process and if psychiatric diagnosis were appropriately assessed, and that that expected timelines for therapeutic effects, and a listing of who, what and how often to monitor for treatment efficacy, was clearly delineated in the treatment plan, and known to the IDT, the Monitoring Team reviewed the psychiatric evaluations for Individuals #140, #139, #84, #3, #66, #2, #54, #134, and #40, and reviewed their clinical record.	Noncompliance

	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.	The Monitoring Team noted that 9, out of 9 (100%) examples included a justifiable diagnosis. Zero out of 9 (0%), ensured that the IDT understood timelines for therapeutic effect, or monitoring criteria to assess efficacy. Conclusion: The Monitoring Team concluded that the Facility remains not in compliance with Provision J13 because it does not ensure that expected timelines for therapeutic effects, and a listing of who, what, and how often to monitor for treatment efficacy, was clearly delineated in the treatment plan, and known to the IDT.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	Following a meeting with the Clinical Director, the Monitoring Team learned that the Facility has not enhanced the consent process since the last Monitoring Team review; however, the facility is completing a draft consent form that emulates local, community standard, consent process. The Monitoring Team reviewed the draft consent form on site, and concurred with its appropriateness. The process did not require the psychiatrist to make direct contact with the LAR; therefore, provision of information is not done by the person most able to ensure all required information is provided. The Facility sent a medication handout listing side effects to the LAR; this form did not, though, identify limitations on the use of the medication in the psychiatric prescription plan for the individual. The consent form itself was essentially a checklist of what was provided to the LAR, and did not discuss specific risks and benefits of recommended treatment versus alternative treatments including no treatment. Conclusion: Because there has been no improvement since the last review by the Monitoring Team, it is determined that the Facility remains not in compliance with Provision J14. Compliance will require that informed, written consent is provided to the legally	Noncompliance

		responsible person before administering non-emergency psychotropic medications. The Facility is strongly encouraged to implement the draft consent process, following appropriate reviews and approvals.	
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 he had been unsuccessful in getting the community neurologist to participate in direct discussion about treatment issues with the psychiatrist. The Facility reports that it will consider developing a contractual arrangement with neurology that will better enable collaboration among psychiatry and neurology. Conclusion: Because the Facility did not have a functional procedure, and practice that ensures collaboration between neurology and psychiatry, for those Individuals who are prescribed medication to treat both psychiatric and neurologic conditions, the Monitoring Team determined that the Facility remains out of compliance with Provision J15.	Noncompliance

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

1. Begin collaboration with psychology services and develop a mechanism to ensure that appropriate behavior data is incorporated into psychiatric assessments, and used when deciding on pharmacotherapy and other treatments. Also ensure that alternative treatments to pharmacotherapy are considered when developing psychiatric treatment plans. (Provision J2)
2. Develop a comprehensive assessment process to ensure that all individuals are appropriately assessed for pre-treatment sedation. (Provision J4)
3. Review the staffing plan for psychiatric services and ensure an adequate staffing to meet the needs of individuals served by the Facility. (Provision J5)
4. Enhance the psychiatric evaluations, to include the psychologist, and ensure that the least intrusive and most positive interventions are developed and incorporated into the psychiatric treatment action plan. (Provision J9)
5. Ensure that IDT meeting that occurs at the time of psychiatric evaluations includes the psychiatrist, nurse, psychologist and primary care physician, and reviews the potential risk and benefits effects of the Individuals mental illness and proposed treatment plan. (Provision J10)
6. When developing psychiatric treatment plans, ensure that expected timelines and how, who, and what is to be monitored to assess treatment efficacy, is well delineated in the assessment, reviewed by the IDT, and integrated into the ISP. (Provision J13)
7. Update the current consent form to reflect standard of care practice. The proposed consent form appears adequate, as long as it is approved by the State. (Provision J14)
8. Enhance collaboration between psychiatric and neurology services and ensure that the treatment plans for individuals who are treated for comorbid conditions are developed jointly. (Provision J15)
9. Ensure that the Facility conducts regular assessments of polypharmacy use for both Individual and Facility. Polypharmacy assessments should

include data collection, trends analysis, recommendations, and specific action steps to reduce polypharmacy, when clinically appropriate.

10. The Facility must enhance its process to ensure that monitoring of TD is timely, effective, and occurs more frequently when necessary, and that physicians review and complete the assessments, and provide meaningful comments by document their concerns, and action steps for clinically abnormal findings.

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 Self-Assessment and Action Plans 2. RGSC Section K Evidence Book 3. Minutes for the Peer Review Committee (10/01/2011 – 03/01/2012) 4. Contracts for professionals 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 Self-Assessment and Action Plans and included Individuals #31, #46, #51, #60, #66, #76, #84, #97, #127, #134, and #139 **People Interviewed:** 1. Lorraine Hinrichs – Program Director 2. Janie Villa – QDDP Coordinator 3. All QDDPs 4. Vanessa Villarreal, M.Ed. – Interim Psychology Director 5. Samantha Salinas, MSW – Contract Associate Psychologist 6. Cheryl Fielding, PhD, BCBA – Contract Psychologist 7. Alonzo Andrews, M.A., BCBA – Contract Psychologist 8. Direct Care Professionals: Approximately 15 staff members in residences, classrooms and vocational settings **Meeting Attended/Observations:** 1. Quarterly PSP Review Meeting – 2/27/2012 2. Internal Peer Review Committee Meeting – 3/1/2012 3. Human Rights Committee Meeting – 3/1/2012 4. Observations were conducted in all residences, classrooms, vocational settings, and leisure areas on 2/28/2012 and 2/29/2012.
	Facility Self-Assessment: At the time of the site visit, RGSC reported that Provision K1 and Provision K12 were in substantial compliance. The Monitor disagreed with the Facility regarding the status of these two Provisions.

	The Facility provided two documents intended to present the status of current efforts to comply with the Settlement Agreement. The first was a Self-Assessment reflecting measures of progress. The second was the Action Plan that outlined the steps the Facility had identified as critical to satisfying the Settlement Agreement. At RGSC, two issues stood out in the review of the Self-Assessment and Action Plan. The first of these issues involved the lack of organization and consistency in the materials that were presented as evidence. In some circumstances, entire provisions, including some that were listed as reflecting progress in the Self-Assessment such as Provision K12, were not included in the evidence book submitted by the Facility. In other situations, documentation consisted only of materials that implied compliance without providing data, such as training sign-in sheets, or that reflected the lack of a true tracking system, such as emails between staff regarding training or psychotropic medications. The second area of concern that stood out was that the Action Plans typically lacked specific criteria for what was to be completed. For example, the Action Plan for Provision K8 consisted of the statement, "Continue to monitor closely to all the individuals to determine if additional psychological services." There was no indication in this statement of the process by which this was to be completed. Furthermore, the Provision includes additional elements pertaining to the quality of non-PBSP interventions that were not addressed in the Action Plan. Compliance with a Settlement Agreement requires that the Facility invest considerable effort into taking the guidelines in the Settlement Agreement and identifying the specific actions necessary to meet those requirements. In many ways, the Settlement Agreement requires that the Facility complete a task analysis on each provision and use that task analysis to formulate an action plan. There was no indication that RGSC had invested the necessary effort in developing the current Self-Assessment.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RGSC from 2/27/2012 through 3/02/2012. Record reviews continued off-site following the site visit. Based upon information gathered during the current site visit, it was apparent that no provisions of Section K were in substantial compliance with the Settlement Agreement. The Facility, however, had indicated that both Provision K1 and Provision K12 were in substantial compliance. Provision K1 addresses the need to provide staff who are demonstrably competent in applied behavior analysis to develop and implement PBSPs. Although many of the PBSPs at RGSC were in fact developed by a BCBA, the sole BCBA at RGSC was no longer employed by the Facility at the time of the site visit and had not been present at the Facility since late Fall 2011. Furthermore, although attempts had been made by the Facility to obtain the services of a BCBA, at the time of the site visit those attempts had not been successful. Provision K12 addresses the need to ensure that staff has successfully completed competency-based training on PBSPs. To support the assertion of substantial compliance, the Facility provided only training sign-in sheets and samples of training forms. Competency-based training, however, requires that the staff demonstrate competence upon initial introduction of a PBSP, as well as throughout the duration of the

	PBSP. The Facility did not provide evidence of actual competence for staff participating in training. Furthermore, documentation reflected that efforts to deliver on-going competency-based training were at best sporadic and for some PBSPs was never provided. Based upon observations and a review of documentation, there were areas in which the Facility had achieved progress. Records reflected that 99% of individuals living at the Facility had been provided a Psychological Assessment report within the past year. Many elements of the SFAs and PBSPs had also improved considerably. Additionally, many elements of the data graphs were of high quality. Despite the improvements, however, there remained several significant limitations in psychological services at RGSC. Documentation reflected that the collection of behavior data was often inadequate. The data that were available were frequently not used effectively in determining the outcome of interventions, and this had actually regressed since the previous site visit. Furthermore, the Facility had achieved no progress from the baseline site visit in the process of integrating psychological and psychiatric services. The greatest challenge that the Facility faced, however, was the loss of the sole BCBA. At the time of the site visit it was not clear when or how this vacancy would be addressed. As many of the Provisions of Section K necessitate the presence of a BCBA, the Facility will find it difficult to achieve compliance with the Settlement agreement until BCBA services are provided..

#	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.	During previous site visits, Megan Gianotti, M.Ed., who served as the Chief Psychologist for RGSC, had been working toward board certification as a behavior analyst. Shortly after the August 2011 site visit, Ms. Gianotti completed all requirements for board certification, passed the board certification exam, and became a Board Certified Behavior Analyst (BCBA). During the Fall of 2011, however, Ms. Gianotti was absent from RGSC for several weeks, and she was no longer employed at the Facility at the time of the current site visit. The loss of the Chief Psychologist and sole BCBA created a challenge for both the Facility and the Monitor. At the time of the current site visit, Vanessa Villarreal, M.Ed., was serving as interim Chief Psychologist. Although enrolled in the second semester of BCBA classwork, Ms. Villarreal lacked the experience and training provided by Ms. Gianotti. RGSC did have contractual employees who were board certified, but it was unclear whether any would be available to take on the responsibility of completing Structural and Functional Assessments (SFAs) or developing Positive Behavior Support Plans (PBSPs). As historically the Harlingen area had not provided an abundance of potential employees with BCBAs, it was unclear how the Facility would progress toward addressing the Psychology staffing condition.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Under most conditions, the status of a Facility at the time of a site visit can be understood to reflect a single point along a continuing line from a known past to a probable or possible future. This understanding, however, is based upon the assumption that conditions affecting services at the Facility will remain relatively stable. In any organization, the removal of a key employee can significantly alter how the organization will progress. At RGSC, a small facility with a small pool of staff at the professional or administrative level, the loss of the Chief Psychologist could have profound effects upon progression toward compliance with the Settlement Agreement. The longer the position remains vacant, the greater the probability of a significant impact upon compliance. Based upon these circumstances, the ability of the Monitor to assess the status of RGSC concerning Section K and determine compliance with the Settlement Agreement was substantially limited.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	At the time of the site visit, Ms. Vanessa Villarreal, M.Ed., was serving as the Chief Psychologist at RGSC. Ms. Villarreal had been employed at the Facility since just prior to the August 2011 site visit. Ms. Villarreal was enrolled in BCBA courses, but had additional coursework, supervision, and examination requirements to complete before becoming a BCBA. As a result, Ms. Villarreal did not yet satisfy the requirements for this Provision.	Noncompliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	During the 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 longer had the responsibility of reviewing PBSPs for clinical acceptability. During the August 2011 site visit, however, observations and BMC minutes reflected that the BMC continued to function with the authority and responsibility of an internal peer review committee. Furthermore, substantial limitations, such as a lack of members with experience in applied behavior analysis, were noted. It was noted during the current site visit that the internal peer review process had been revised again in October 2011. This revision provided additional psychology staff as	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>members of the peer review committee, and included Cheryl Fielding, PhD, BCBA, as Chair. Dr. Fielding was a contractual employee at RGSC.

Documentation provided by the Facility reflected that the internal peer review committee had met five times since the process had been revised. The Minutes from those five meetings listed the content of the PBSPs reviewed, but did not reflect the review process or decisions by the committee. During the current site visit, no PBSPs were reviewed. Instead, the peer review meeting focused upon further upcoming changes in the peer review process. Because of documentation limitations, as well as both recent and approaching process revisions, it was not possible to assess the status of the internal peer review process.

The Facility reported during the current site visit that no external peer review had been provided under the revised peer review process. It was reported by RGSC staff that the external peer review process would be undergoing additional revisions. Because of these conditions, it was not possible to assess the external peer review process at RGSC.</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 and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.</td><td>During previous site visits at RGSC, observations and record reviews had revealed a diverse use of data collection strategies. At the time of the current site visit, records suggested that data collection procedures had drifted almost entirely to frequency counts of behavior. In addition, problems in obtaining complete and accurate data were discussed in several progress notes and other documents.

A sample of 11 records was selected for review of behavior data. The table below presents information about the quality of the behavior data and the presentation of those data.
<table>
<tr><th></th><th>Baseline</th><th>2/2012</th><th>Change</th></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress.</td><td>0%</td><td>36%</td><td>36%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Data reliability is assessed.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Target behaviors analyzed individually.</td><td>0%</td><td>27%</td><td>27%</td></tr>
<tr><td>Targeted behaviors graphed sufficient for decision-making.</td><td>0%</td><td>45%</td><td>45%</td></tr>
<tr><td>Replacement behaviors graphed sufficient for decision-making.</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>
The table above reflects modest improvement in some areas compared with the baseline measures conducted in February 2010. Although the quality of behavior data is better in comparison with baseline, there in fact had been a substantial decrease in the quality of behavior data in comparison with measured made in August 2011. The table below illustrates the changes since the previous site visit.
<table>
<tr><th></th><th>8/2011</th><th>2/2012</th><th>Change</th></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress.</td><td>62%</td><td>36%</td><td>-26%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress.</td><td>8%</td><td>0%</td><td>-8%</td></tr>
<tr><td>Data reliability is assessed.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Target behaviors analyzed individually.</td><td>38%</td><td>27%</td><td>-11%</td></tr>
<tr><td>Targeted behaviors graphed sufficient for decision-making.</td><td>92%</td><td>36%</td><td>-56%</td></tr>
<tr><td>Replacement behaviors graphed sufficient for decision-making.</td><td>23%</td><td>0%</td><td>-23%</td></tr>
</table>

It is vital that valid and reliable data regarding behaviors, mental illness, and interventions be made available. Without such data, it cannot be demonstrated that PBSPs and other behavior change strategies are beneficial to the individuals receiving such services. Furthermore, the use of restrictive procedures without adequate data can place individuals at unnecessary risk as the need for those procedures cannot be effectively demonstrated and the implementation of those procedures cannot be successfully monitored.

A variety of specific limitations were noted in relation to behavior data.

<u>Assessment of Progress.</u>
To determine the efficacy of behavior interventions, it is necessary to identify the salient characteristics of the target behavior and then develop a process for measuring those characteristics. For most individuals at RGSC, behaviors were being measured by frequency counts. In some cases, frequency measures could capture the relevant characteristics of the behavior. Several individuals in the sample, however, presented targets related specifically to the symptoms of mental illness, such as hallucinations, depression, and mood disturbance. Progress notes and other data summaries reflected that these mental illness targets were also measured by frequency counts or some similar discrete data collection process.
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Symptoms of mental illness are often not considered to be events with clear beginnings and endings. Instead, symptoms of mental illness often are presented for extended periods during which there may substantial fluctuations. It was unclear how the data collection procedures at RGSC effectively captured accurate information about mental illness. It is possible to identify behavior analogs or markers for mental illness symptoms. To do so, however, requires comprehensive assessment and the development of operational definitions for the identified behaviors. There was no indication that RGSC had implemented any such efforts in relation to mental illness symptoms. It was therefore not possible for the Facility to effectively measure the treatment targets or monitor the benefit from the implemented interventions. <u>Replacement Behavior Data</u>. Replacement behaviors are those behaviors that are selected to be taught to the individual to replace the undesired behavior. Many of the PBSPs reviewed included replacement behaviors to be taught. None of the Progress Notes or other documentation included in the sample, however, presented any data for how well the individuals had learned the replacement behavior. As a result, it could not be demonstrated that any individual in the sample had learned to use the replacement behavior instead of the undesired behavior.. • The PBSP for Individual #60 included a component for teaching appropriate sexual expression as a replacement behavior. Although the data reflected the incidents of inappropriate sexual behavior, data regarding the acquisition of the replacement behavior were not included. There was no way to determine whether the individual was acquiring the replacement behavior, or if the teaching procedure was even functional or beneficial for the individual. <u>Data Reliability</u>. Reliability is a measure of how well a data collection procedure produces agreement across multiple people collecting data. A common practice for determining reliability is to compare the data collected by two people at the same time and regarding the same behavior. The less the data produced by the two people agree, the greater the chance that the data collection procedure is inadequate. In the sample of records during the current site visit, there was no indication of data reliability on the Progress Notes or other data summary documentation. Without reliability information, it was not possible to determine if changes in the data were due to changes in the individual's behavior or simply due to an unreliable data collection process. It was therefore not possible to determine, based upon the available data, what effect the intervention was producing. <u>Individually Analyzed Target Behaviors</u>.	

#	Provision	Assessment of Status	Compliance
		When reviewing data to determine treatment efficacy, it is important to avoid organizing unrelated behaviors into a single class or group. If unrelated behaviors are grouped, it is possible that a change in one of those behaviors will be masked or unnoticed. When that occurs, an intervention may inadvertently be stopped or continued without adequate justification. At RGSC, analyzing efficacy of single behaviors was most commonly seen in PBSPs with a single target. If a PBSP included multiple target behaviors, the tendency was to estimate progress based upon all of the targets regardless of whether a functional relation existed, as the different targets might have different functions and might separately increase, decrease, or remain the same in response to the intervention. Thus, the different changes in the different behaviors might wash out in the data. Even if each behavior is separately measured, considering them all together may result in continuation of a program that is ineffective for one, without revising the program for the other behavior. • Individual #134 was provided a PBSP that included Disruption and Verbal Threats as two of the target behaviors. Verbal threats dropped to zero displays in September 2011 and remained at zero displays through the time of the site visit. Displays of aggression during that same period tripled before leveling at twice the September 2011 frequency at the time of the site visit. This suggested that the PBSP may have been effective for Verbal Threats, but not for Disruption. As the determination of progress was based upon the response of all target behaviors, the recommendation was to continue the PBSP without revision even though it had not been effective at reducing Disruption. <u>Behaviors Graphed Sufficient for Decision Making</u>. Approximately 55% of the sample did not include graphs of target behaviors that were sufficient for decision-making. This was largely due to the use of inappropriate measures for the target behavior. In relation to replacement behaviors, there were no graphs in the sample that included replacement behavior. Based upon the available information, it was evident that RGSC was unable to provide adequate data collection and presentation for the majority of individuals living at the Facility. Despite limitations in the collection and presentation of behavior data, RGSC had demonstrated progress in some components of the data review and treatment decision process. | | Baseline | 8/2011 | Change | | Graphed data are reviewed monthly or more | 0 % | 100% | 100% |	

#	Provision	Assessment of Status				Compliance
		frequently if needed, such as due to use of restraints or changes in risk level.				
		Review is conducted by a BCBA.	0%	0%	0%	
		Input from direct care staff is solicited and documented.	0%	0%	0%	
		Modifications to the PBSP reflect data-based decisions.	0%	27%	27%	
		Criteria for revision are included in the PBSP.	0%	18%	18%	
		Progress evident, or program modified in timely manner (3 Months).	0%	55%	55%	

In a sample of 11 records, all records included documentation of a monthly review of PBSP data. In addition, slightly over half of the records reviewed reflected that the PBSP had been reviewed or revised if three months had passed without demonstrable progress. This left roughly half the individuals lacking the necessary reviews that could have identified the specific reasons for the lack of progress, as well as the appropriate response, such as program revision, staff training or other measures.. Despite the noted issue with review, this reflected meaningful progress over baseline conditions.

Unfortunately, other components vital to the review process had improved only modestly or not at all. None of the records in the sample reflected that a BCBA, the person best trained for the task, had completed the monthly review. In addition, there was no indication in the sampled records that input from direct care staff had been integrated into the review process.

Most disturbing was the failure of the Facility to utilize evidence-based practices when conducting the reviews of treatment data. In only 18% of records reviewed did the PBSP include full criteria for what constituted progress (when the PBSP should be continued) and lack of progress (when the PBSP should be revised). In several PBSPs, criteria for success were defined but criteria for lack of progress were not. When criteria for lack of progress are not included, the risk of continuing an ineffective or even detrimental intervention is increased. Therefore, the PBSPs at RGSC lacked a critical component in the decision making process.

The sampled records also reflected that treatment decisions could be supported by the available data in approximately only one in four cases. This condition indicated that, even though interventions were being revised more frequently, it was not clear the revisions could be supported by the available data.

- The progress notes for Individual #76 reflected four changes in psychotropic medication prescribed for behavior during 2011 although no data were provided

#	Provision	Assessment of Status	Compliance
		until December of 2011. • For Individual #134, following the implementation of a PBSP in August 2011, verbal threats increased and remained above pretreatment levels through January 2012. During that same period, measures of mental illness remained at zero. Despite these circumstances, no revision to the PBSP was attempted, but psychotropic medications were increased twice. Based upon the information obtained during the site visit, it was evident that data collection, presentation, and use at RGSC remained inadequate.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	At the time of the current site visit, approximately 99% of the individuals living at RGSC had received a psychological evaluation in the past year. In February of 2011, only 19% of individuals had received a psychological evaluation. These data indicated that RGSC had achieved considerable improvement in the provision of psychological evaluations. Not all of the completed psychological evaluations included intellectual and adaptive behavior assessment findings. Due to conflicting documentation provided by RGSC (discussed below), it was not possible to determine the exact number of individuals who had been provided intellectual and adaptive behavior assessments. Despite the conflicting documentation, it was evident that the Facility had attempted to provide the necessary testing and had demonstrated progress in this area. Assessing the content of the psychological evaluations proved to be more difficult. A sample of 11 records reviewed following the site visit revealed that 73% of the records included both intellectual and adaptive test findings. As this reflected a substantial increase from previous findings, it was decided to review documents provided by RGSC involving the completion of intellectual and adaptive testing. The Monitoring Team discovered that RGSC had submitted two documents that included completion information on testing (QMRP Caseloads tracking sheet for Psychological Evaluations from the Section K Evidence Book and Psychology Tracking Log), and that these two documents differed substantially on the number of completed assessments. Furthermore, the testing information on both RGSC documents differed considerably from the completion information gathered from the sample. Therefore, it was not possible to establish the number of completed intellectual and adaptive assessments. During the current site visit, a sample of 13 Structural and Functional Assessments (SFAs) was selected. Information collected from this sample revealed considerable improvement over baseline at the Facility, as well as over findings from August 2011. | | 1/2010 | 2/2012 | Change |	Noncompliance

#	Provision	Assessment of Status				Compliance
		If the individual's record or assessments reflect behavioral disturbance or psychopathology, a functional assessment that includes the following is incorporated into the standard psychological assessment.				
		Assessment or review of biological, physical, and medical status	0%	91%	91%	
		Review of personal history	0%	73%	73%	
		A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	0%	82%	82%	
		The process or tool utilizes both direct and indirect measures	0%	82%	82%	
		Identification of setting events and motivating operations relevant to the undesired behavior	0%	64%	64%	
		Identification of antecedents relevant to the undesired behavior	0%	64%	64%	
		Identification of consequences relevant to the undesired behavior	0%	64%	64%	
		Identification of functions relevant to the undesired behavior	0%	64%	64%	
		Summary statement identifying the variable or variables maintaining the target behavior	0%	64%	64%	
		Identification of functionally equivalent replacement behaviors relevant to the undesired behavior	0%	64%	64%	
		Identification of preferences and reinforcers	0%	0%	0%	
		Although the SFAs included in the site visit sample reflected improvement, it was not evident that the practices that resulted in the improvement would continue. As indicated previously in the report, the person responsible for the development of SFAs at RGSC was no longer employed at the Facility. Furthermore, the Facility did not employ any other staff with the experience and training required to complete SFAs. Efforts to arrange for additional personnel had not proven successful up to the time of the current site visit. Future reviews will be necessary to determine if RGSC can maintain progress toward compliance with the Settlement Agreement in this area. One area of continued weakness was noted in relation to the SFA. The review of 11 SFAs revealed only minimal attention was directed toward integrating environmental functions of behavior and the symptoms of mental illness into the assessment process.				

#	Provision	Assessment of Status	Compliance
		Ten of the 11individuals (91%) included in the sample were prescribed psychotropic medication within the past 12 months, and all 11 had been given a diagnosis of a mental illness in addition to mental retardation. Only one of the 11 SFAs (9%), however, attempted to identify the influence of environmental variables upon mental illness or explore how mental illness might affect learned behavior. As a result, the information provided by the SFAs was of limited benefit, as all factors had not been fully explored.	

	2/2010	2/2012	Change
Screening for psychopathology, emotional, and behavioral issues	0%	18%	18%
Differentiation between learned and biologically based behaviors.	0%	9%	9%
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%

The lack of integration between psychiatric and psychological services resulted in several limitations in the implementation and tracking of interventions.

- The records for Individual #31 revealed an inconsistent array of psychiatric diagnoses, including Childhood Disintegrative Disorder, Pervasive Developmental Disorder, and Severe Speech Disorder. The most recent SFA presented two intervention targets: Self-injury and Aggression. The individual was prescribed Klonopin and Remeron to address these behaviors, although the SFA reflected an environmental basis for the behaviors.
- Individual #97 was provided a variety of psychiatric diagnoses, including Autistic Disorder, Obsessive-Compulsive Disorder, Intermittent Explosive Disorder, Behaviors targeted by the SFA included ritualistic spitting, head-touching, and public urination. To address these targets, the individual was prescribed Xanax, Seroquel, Lexapro, and Haldol. There was no indication in the record of an integrated assessment and treatment plan.
- Individual #134 was diagnosed with Intermittent Explosive Disorder and Psychotic Disorder NOS, and was prescribed Klonopin, Seroquel, and Trileptal. The SFA included only Disruption and Verbal Threats as target behaviors, although Hallucinations were also listed as a target on the Progress Note. The record did not reflect an attempt to investigate the relationship between environmental variables and the sole symptom of mental illness identified as a target. Furthermore, the data provided reflected essentially non-existent hallucinations.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Overall, information obtained from observations and documentation during the site visit reflected a mixture of progress and continued weaknesses. Any efforts by the Facility to maintain the progress or address the weaknesses would be hampered by the lack of psychology staff with adequate training and experience. The issue of primary importance for RGSC, therefore, was the need to strengthen personnel.</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 Provision K5, it was not evident that assessments were based on current, accurate, and complete clinical and behavioral data.

Examples of an inadequate assessment process included the following.
Although documentation by the Facility varied, RGSC reported that as many as 56 individuals had not been provided an intellectual or adaptive assessment in the past year.
Only nine percent of sampled SFAs included symptoms of mental illness in the functional assessment process
Only 64% of sampled SFAs included the identification of setting events, motivating operations, antecedents and consequences for all treatment targets.</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 reflected that individuals newly admitted to the Facility had a psychological assessment completed within 30 days of admission. Records did not reflect that individuals admitted to the facility routinely received an intellectual or adaptive assessment at the time of admission regardless of the amount of time since the most recent assessment.

A review of records also revealed that all but one individual had been provided a psychological assessment within the past year. This reflected substantial progress for the Facility regarding both the completion and timeliness of psychological assessment reports. As documented in Provision K5, however, it was not possible to establish the number of individuals for whom intellectual and adaptive assessments had been completed as part of the psychological assessment process. 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>2/2012</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>99%</td><td>99%</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>
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<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The psychological assessment process includes, where necessary, the development of an SFA to investigate the factors maintaining displays of target behaviors. Evidence obtained as part of the site visit reflected SFAs for all individuals were developed or reviewed within the past year. Documentation did not reflect, however, that SFAs had been reviewed as often as necessary based upon response to the PBSP. Due to personnel issues discussed elsewhere in this report, it was not clear whether the Facility would be able to provide staff with adequate experience and training to complete SFAs in the future.

Based upon observations, record reviews and conditions at RGSC at the time of the site visit, it was not evident that the Facility had achieved the necessary progress in relation to the requirements of Provision K7 or would be able to do so in the near future.</td><td></td></tr>
<tr><td>K8</td><td>By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.</td><td>No individuals living at RGSC at the time of the site visit were participating in counseling, psychotherapy, or any psychological service other than a PBSP. There was no indication in documents provided to the Monitoring Team that this was reviewed for any individual by the IDT 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 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</td><td>The records of 11 individuals were reviewed regarding consents and approvals for restrictive procedures, including behavior interventions and psychotropic medications. In the cases reviewed, only 36% of the individuals had received necessary consents and approvals that met all expectations. This is reflected a substantial drop in comparison with previous site visits. During the August 2011 site visit, RGSC had demonstrated adequate consents and approvals for 85% of the cases reviewed.

<table><tr><th></th><th>Baseline</th><th>2/2012</th><th>Change</th></tr><tr><td>Necessary consents and approvals are obtained for each PBSP and safety plan prior to implementation.</td><td>78%</td><td>36%</td><td>-42%</td></tr></table>
A variety of factors contributed to the regression at RGSC in this area, such as:
• Three individuals (Individuals #51, #66, and #97) had no documentation of consent for restrictive procedures.
• Two individuals (Individuals #31 and #76) had consents in place that at the time of the site visit were in excess of 365 days old.

In addition to the issues with the consents and approvals for the individuals in the</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>written extension based on extraordinary circumstances.</td><td>sample, there were also indications of numerous rights violations associated with the Human Rights Committee review process. In the six months prior to the current site visit, RGSC had documented 20 occurrences in which individuals could not be reviewed due to a failure of the QDDP to submit the necessary paperwork in a timely manner.

Based upon record reviews and observations, it was evident that RGSC was unable to provide thorough and timely protections for individuals who were exposed to restrictive practices.

A sample of 11 records was selected to assess progress related to the development of PBSPs. The findings from the review are presented in the table below. Based upon the information obtained from the sample, RGSC had achieved progress across most Provisions in comparison with the original baseline visit, as well as the August 2011 site visit. As stated previously in this report, however, RGSC no longer employed the individual responsible for the development of PBSPs, nor was there a person currently employed at the Facility with the training and experience necessary for PBSP development.

<table>
<tr><td></td><td>2/2010</td><td>2/2012</td><td>Change</td></tr>
<tr><td>Rationale for selection of the proposed intervention.</td><td>0%</td><td>73%</td><td>73%</td></tr>
<tr><td>History of prior intervention strategies and outcomes.</td><td>0%</td><td>36%</td><td>36%</td></tr>
<tr><td>Consideration of medical, psychiatric and healthcare issues.</td><td>0%</td><td>9%</td><td>9%</td></tr>
<tr><td>Operational definitions of target behaviors.</td><td>0%</td><td>55%</td><td>55%</td></tr>
<tr><td>Operational definitions of replacement behaviors.</td><td>0%</td><td>73%</td><td>73%</td></tr>
<tr><td>Description of potential function(s) of behavior.</td><td>0%</td><td>55%</td><td>55%</td></tr>
<tr><td>Use of positive reinforcement sufficient for strengthening desired behavior</td><td>0%</td><td>18%</td><td>18%</td></tr>
<tr><td>Strategies addressing setting event and motivating operation issues.</td><td>0%</td><td>64%</td><td>64%</td></tr>
<tr><td>Strategies addressing antecedent issues.</td><td>0%</td><td>64%</td><td>64%</td></tr>
<tr><td>Strategies that include the teaching of desired replacement behaviors.</td><td>0%</td><td>91%</td><td>91%</td></tr>
<tr><td>Strategies to weaken undesired behavior.</td><td>0%</td><td>27%</td><td>27%</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 data collection procedures.</td><td>0%</td><td>36%</td><td>36%</td></tr>
<tr><td>Baseline or comparison data.</td><td>0%</td><td>91%</td><td>91%</td></tr>
<tr><td>Treatment expectations and timeframes written in objective, observable, and measureable terms.</td><td>0%</td><td>36%</td><td>36%</td></tr>
<tr><td>Clear, simple, precise interventions for responding to the behavior when it occurs.</td><td>0%</td><td>0%</td><td>0%</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>0%</td><td>91%</td><td>91%</td></tr>
</table>

Based upon the information obtained from the sample, RGSC had achieved progress across most Provisions in comparison with the original baseline visit, as well as the August 2011 site visit. As stated previously in this report, however, RGSC no longer employed the individual responsible for the development of PBSPs, nor was there a person currently employed at the Facility with the training and experience necessary for PBSP development.
</td><td></td></tr>
<tr><td>K10</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.</td><td>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 measures of interobserver agreement (IOA) were not in place at the Facility. This lack of reliability measures reflected that the Facility had made no progress since the baseline site visit. As reliability data were not collected, data graphs did not include measures of reliability.
<table>
<tr><td></td><td>Baseline</td><td>2/2012</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.
</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><th>Graph Element</th><th>2/2010</th><th>2/2012</th><th>Change</th></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>0%</td><td>36%</td><td>36%</td></tr>
<tr><td>Horizontal axis and label</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Vertical axis and label</td><td>0%</td><td>91%</td><td>91%</td></tr>
<tr><td>Condition change lines</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Condition labels</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Data points and path</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>IOA and data integrity</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Demarcation of changes in medication, health status or other events</td><td>0%</td><td>100%</td><td>100%</td></tr>
</table>

The greatest problem noted in the behavior data graphs other than lack of information on 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, which 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>
<tr><td>K11</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.</td><td>A 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. While this reflected a strength in relation to PBSPs, RGSC reported no procedures for monitoring or ensuring that PBSP instructions were written in a easily readable manner.

Despite readable PBSPs and acknowledgement by DSP staff that PBSPs were not difficult to understand, Psychology staff reported incidents of PBSPs not being implemented. 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.</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>

Individual #80 was observed being poorly compliant with training activities. When prompted by staff to cooperate, the individual struck himself in the head multiple times. Staff did not act to block the blows. The PBSP required staff to utilize communication pictures in order to identify the individual's needs when self-injury was presented. No effort to facilitate communication was observed. When asked, staff reported that they were to prevent the individual from harming himself.
Individual #3 was observed picking up small items from around a trashcan and placing these in a one-pint milk carton. He engaged in the behavior for several minutes before staff attempted to interrupt the behavior. When difficulty was encountered in interrupting the individual, staff left the area and returned several minutes later with a small basket for the individual. Staff encouraged the Individual to put items in the basket rather than the milk carton. When asked, staff provided no clear concept of how to address the behavior although it was indicated that the behavior was common for the individual. The Monitor informed staff that the Individual had not attempted to ingest any of the items picked up. Staff stated that they did not think the individual was known to ingest inedible items; the individual had a PBSP, but the staff member did not indicate whether this behavior was addressed.

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 act diligently to ensure that all individuals receive necessary services and that protection from unnecessary risks is maintained.
</td><td></td></tr>
<tr><td>K12</td><td>Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.</td><td>
In documentation provided by RGSC, it was not evident that efforts to provide competency-based training for PBSPs were conducted with necessary diligence. For individuals in the Section K sample, the following information was provided regarding PBSP training.
<table>
<tr><th>Individual</th><th>Training on PBSP Implementation Procedures</th><th>Monitoring of PBSP Implementation Skills</th></tr>
<tr><td>Individual #31</td><td>1/17/2012, 1/20/2012, 1/26/2012</td><td>None</td></tr>
<tr><td>Individual #46</td><td>11/10/2011, 11/11/2011, 12/9/2011, 12/22/2011</td><td>11/11/2011</td></tr>
<tr><td>Individual #51</td><td>12/9/2011, 12/22/2011</td><td>None</td></tr>
<tr><td>Individual #60</td><td>1/7/2011, 6/30/2011,</td><td>None</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

	1/20/2012	
Individual #66	1/20/2012, 2/9/2012	None
Individual #76	1/20/2012	None
Individual #84	10/28/2011	None
Individual #97	8/9/2011, 8/16/2011, 11/10/2011, 11/8/2011	8/9/2011, 8/16/2011, 11/10/2011, 11/8/2011
Individual #127	11/10/2011, 11/11/2011	11/11/2011
Individual #134	8/12/2011, 8/19/2011, 10/28/2011	8/12/2011
Individual #139	8/12/2011, 8/19/2011, 10/28/2011, 12/9/2011, 12/22/2011	None

Competency-based training requires that a multifaceted training approach be implemented. This must include comprehensive training to ensure that all staff is familiar with and competent to implement PBSP procedures at the time of initial PBSP implementation. In addition, there must be an ongoing effort to ensure that, once staff is determined to be competent, that competence continues through the duration of the PBSP. Additionally, each revision of the PBSP requires that the entire process begin anew.

Documentation indicated that training on PBSP implementation was conducted to familiarize staff with the content of PBSPs. Records did not reflect, however, that such training was provided to every staff member responsible for the implementation of a PBSP. Additionally, although demonstrations, modeling, or staff exercises could be included, it was not evident that such training procedures were used consistently or frequently. Efforts to provide ongoing PBSP training involved interacting with staff during the course of their daily duties at which time they were asked to describe or demonstrate how to implement a PBSP. As illustrated in the table above, staff was often provided some form of initial training on PBSP content. Efforts to ensure that staff maintained competence on each PBSP, however, were sporadic and often had not been attempted during the past six months. An additional weaknesses in staff training during the site visit included the lack of a system to ensure that pulled and relief staff receive competency based training on PBSPs they will be responsible to implement.

Based upon information obtained during the site visit, it appeared that the Facility had conducted some training on the PBSPs developed to address undesired behavior. Evidence did not support, however, that the Facility had acted to ensure that all staff had initially demonstrated, as well as maintained, competence regarding each PBSP for which they were responsible.

#	Provision	Assessment of Status	Compliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the site visit, RGSC employed no staff who was board certified in applied behavior analysis. Two staff were enrolled in classes required for board certification. When those two staff obtain board certification, the Facility will still fail to meet the requirement of one BCBA for every 30 individuals living at the Facility, based upon the current facility census. RGSC employed two Psychology Assistants. Based upon a presumption of board certification for all eligible staff, the number of Psychology Assistants would meet the requirement of the SA.	Noncompliance

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

1. The Facility should pursue arranging for services from one or more BCBAs to address the current vacancy. Additionally, it is recommended that the Facility continue to strengthen the applied behavior analytic skills of the individuals currently employed. (Provisions K1, K2 and K13)
2. The Facility needs to identify and maintain a set of practices for peer review. The frequent revisions to the practices makes it difficult to ensure that PBSPs received adequate clinical review. (Provision K3)
3. The Facility is encouraged to develop and implement a comprehensive system of data collection, presentation and review. This system should include behaviors targeted for increase as well as reduction, as well as integrate the collection of data relating to mental illness. It is also critical that a process for determining the validity and reliability of data be incorporated into the data collection system. (Provisions K4 and K10)
4. It is critical that the Facility integrate psychology and psychiatry services throughout the behavior assessment and intervention process. SFAs need to include a process to differentiate between environmentally based behaviors and those behaviors that are identified markers for symptoms of mental illness, as well as where the two overlap. In addition, the tracking of treatment response needs to include both behavior and mental illness. (Provision K5)
5. RGSC needs to be more diligent in the provision of intellectual and adaptive testing, and ensure that test findings are incorporated into the ISP process. (Provision K5)
6. Although no individuals were provided psychological services other than PBSPs at the time of the site visit, the Facility needs to be prepared for when the need does arise. RGSC should develop a system to ensure that non-PBSP services reflect an evidence-based approach to intervention. (Provision K8)
7. RGSC should develop and implement a system to ensure that risk violations, especially those due to failure to submit paperwork in a timely manner, are prevented. (Provision K9)
8. The Facility should develop and implement a system that ensures that PBSPs include all necessary elements prior to those PBSPs being implemented. (Provision K9)
9. RGSC should develop a process for measuring the readability of intervention instructions and ensuring that PBSPs can be easily read and implemented by staff. (Provision K11)
10. Competency-based training at RGSC did not include a method for tracking staff competence at PBSP implementation or throughout the duration of the intervention. RGSC must develop such a system and takes steps necessary to ensure that all staff are able to demonstrate competence in the PBSPs for which they are responsible. (Provision K12)

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-Assessment and Action Plan 2/13/12 2. RGSC Section L Presentation Book 3. Standard Operating Procedure, ICF-MR 400-14, dated December 9, 2010 4. Physician CPR certificates 5. Physician CME certification 6. Immunization records for Individuals #31, #101, #141, #21, #134, and #139 7. Clinical record review for Individuals #5, #80, and #29 8. Most recent PT/OT assessments and three year PT/OT assessment; most recent annual medical assessment; past 12 months labs, x-rays, and consultations; most recent ISP and subsequent addendums to the ISP for Individuals #126, #21, and #69 9. Past 12 Months PT/OT reports, physician notes, external consultation reports, ISP reports; all available diagnostic and orthopedic consult reports for past 3 years; annual medical assessment; nursing assessment for Individuals #115, #15, #61, and #140 10. Annual ISP; most recent annual medical assessment, PT/OT evaluation, endocrinology consultation; last 12 months laboratory tests; last two DEXA scan reports; current medication list for Individuals #69, #27, #91, #54, #8, #118, #98, and #4 11. Forms and results of round 2 Medical Provider Quality Assurance Audits for the Facility, dated October 2011 12. Preventive Health Care Guidelines, dated August 30, 2011 **People Interviewed:** 1. John Partin, MD – primary care physician 2. Brian O'Donnell, MD – primary care physician 3. David Moron, MD – Clinical Director **Meeting Attended/Observations:** 1. Morning Medical Rounds, February 26, 2012 2. The following Individuals were observed at their living area: Individuals #31, #101, #141, #21, #134, #139, #5, #13, #29, #126, #21, #69, #115, #15, #61, #140, #27, #91, #54, #8, #118, #98, and #4
	Facility Self-Assessment: The Facility reported that it remains noncompliant with Provisions L1 through L3, and the Monitoring Team concurs with the Facility and determined them to be noncompliant with provision L1, L2, and L3. The Self-Assessment reports that the Facility is utilizing the DADS Clinical Guidelines; however, during this review, the Facility's physicians commented on the limited usefulness of the guidelines. The Monitoring Team continues to raise concerns of the guidelines. The Facility reported that it was in substantial compliance with provision L4. The Monitoring Team disagrees with this assessment, and determined the Facility to remain noncompliant with the provision. The Self-Assessment commented that it had operationalized the Medical Services Policy, but the Monitoring Team noted that the Facility is not following the policy, especially in areas of integrating health care issues

	through the team process, and follow-up to care. Importantly, the Self-Assessment focuses on the Facility's integration of the Medical Services Policy, but its action plan outlines the Facility's implementation of the protocols on preventative care, seizures, constipation, and enteral feeding. This incongruence delineates the Facility's challenges in developing a meaningful, congruent, action plan, that establishes a comprehensive pathway to substantial compliance.
	Summary of Monitor's Assessment: Provision L1: Overall, the provision of medical services has significantly improved. Physicians are appropriately and promptly addressing acute medical issues, hospital follow-up care, documentation practice, management of complicated chronic conditions, are areas of significant improvement. In general, individuals are medically triaged appropriately and the physician staff has demonstrated very good clinical management. The Facility recognizes that it still have many obstacles to overcome, and must better address certain conditions that are common to individuals with developmental disabilities, improving on its immunization strategy, integrating health care issues into the team process, and developing a functional, and accurate management system for clinical data, which will enable real time reports such as current diagnosis, updated problem lists, and enable rapid the query of clinical data elements, such as providing a physician with an accurate reflection of current A1C values. Although there has been much improvement, the Facility in not in compliance with Provision L.1. Provision L2: The Facility has not effectively implemented the State's Medical Provider Quality Assurance Audit process. In addition, there is some concern that external physician reviewers that conduct these reviews are not accurately identifying outcomes based on the work completed by the reviewed physician, and do not take into consideration the work of other physicians who perform activity within the clinical record, which could be misleading. Also, the Facility has developed its own process for conducting internal reviews, to help them prepare for the State Audits. This process, however, does not have a written procedure, nor has it been functional to date. For these reason, the Monitoring Team determined that the Facility is not in compliance with Provision L2. Compliance will require adherence to DADS State Policy for External Audits, and enhancing the DADS Medical Provider Quality Assurance Audit by including a robust clinical performance component, to assess the clinical abilities of physicians. Provision L3: Because the Facility had not implemented a QA process for medical care, the Monitoring Team determined that the Facility is not in compliance with Provision L.3. The Facility must develop and implement a meaningful QA medical review process to assess clinical outcomes and ensure the provision of medical care meets or exceeds generally accepted standard of care practices. The process must include a mechanism to collect, store and conduct longitudinal trends analysis of clinical care. Provision L4: The Monitoring Team determined that the medical policies and procedures provided for review were either not implemented at the Facility, or are inadequate. For these reason the Monitoring Team

	determined that the Facility is not in compliance with Provision L.4. Compliance will require careful review of all clinical policies, and procedures, ensure that they are fully implemented, and ensure that they are appropriate for providing health care to individuals with developmental disabilities.

#	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.	To assess compliance with Provision L.1, the Monitoring team observed individuals at the living area and assessed for signs of neuromotor, musculoskeletal, and general illness; based on observations, the Monitoring Team selected individuals to evaluate by a clinical record review. In addition, the Monitoring Team talked with physicians about practice related issues, reviewed clinical data, and assessed treatment approaches for various conditions, including neuromotor, musculoskeletal, diabetes, osteoporosis, immunization and vaccination strategies, and management of acute clinical conditions. The following topics provide detail of the findings. <u>Staffing for Medical Services</u> To assess medical staffing, the Monitoring Team reviewed the physician and support staffing for Medical Services, and assessed continuing medical education and basic life support qualifications. The Facility had significantly enhanced professional and support services for medical services. At the time of this review, the Facility had 1.25 full time equivalent (FTE) primary care physician staff, and 1.0 FTE administrative support staff dedicated to medical services. The Facility also ensured adequate cross coverage for staff on leave or vacation. Two of two physicians are currently certified in healthcare providers basic life support (100%). Both physicians had exceeded the annual required for CME credits for 2011 (60.74, and 38.25 CME hours). CME was not specific for developmental disabilities Conclusion: The Monitoring Team compliments the Facility on the high caliber and observed dedication of the Facility's primary care staff. It would be advantageous if additional training in developmental disabilities could be identified and provided. Examples would include educational venues for specific syndromes, such as Down's Syndrome, and neuromotor conditions, such as Cerebral Palsy. <u>Medical Data</u> Upon arriving at the Facility, the Monitoring Team provided a list of medical conditions	Noncompliance

#	Provision	Assessment of Status	Compliance
		and asked for a list of all individuals who had such conditions. After 48 hours, the Monitoring Team was informed that the Facility could not provide the information. The Monitoring Team determined that lack of "real-time" access to such data-elements limits the ability of the Facility and its health care providers to provide and improve quality of health care services to individuals served. Conclusion: Without developing a meaningful system that will enable an accurate and immediate list of all health care conditions, including an accurate and updated diagnosis, and problem list for each individual, as well as being able to query clinical data elements, the Facility will not be able to gain compliance with Provision L1. <u>Provision of General Medical Care</u> The Monitoring Team reviewed the following clinical records to assess physician documentation practice and delivery of medical services, including the management of acute and chronic conditions, preventive healthcare and immunization, and do not resuscitate (DNR) orders: Individuals #141, #21, #134, #139, #5, and #13. The Monitoring Team noted exceptional clinical documentation and appropriate initial management of acute medical conditions. The Monitoring Team also noted exceptional follow-up by the physician of those individuals who required hospitalization. Follow-up evaluation through resolution of the condition by the physician was not consistent. For example, for Individual #5, a post surgical assessment by the physician on 1/30/12, was well documented in SOAP format, however, the Monitoring Team could not identify documentation where the physician followed this issue to resolution. The Monitoring Team was made aware that the Facility is developing a clinic model that will ensure prompt and regular physician follow-up for all acute, and chronic conditions, and if implemented, should resolve the follow-up to resolution issue. Conclusion: The Monitoring Team clearly recognizes the substantial improvements noted in the management of medical conditions at the Facility. All physicians are appropriately and promptly addressing acute medical conditions, and physicians are consistently documenting in the SOAP format. Individuals hospitalized are closely followed and monitored by the Facility physician. The Monitoring Team compliments the Facility's physicians for their excellent progress. <u>Preventive Care/Immunization</u> To determine if the Facility adheres to the Centers for Disease Control guidelines for immunization practice, the Monitoring Team requested copies of immunization records and CDC recommended proof of immunization for measles, mumps, rubella (MMR), and	

#	Provision	Assessment of Status	Compliance

initial immunization for tetanus and pertussis. The CDC guidelines require that proof of immunization be a physician statement, laboratory confirmation test, or health department record. Verbal reports by parents or others are not acceptable for proof of immunization. The Monitoring Team recognizes the importance of accurate immunization records, especially as some conditions such as measles and pertussis are re-emerging. The following table indicates which individuals had proof in their records of immunizations for MMR and Pertussis.

Individual	MMR	Pertussis
#31		
#101		X
#141		
#21	X	X
#139		
#134		X

Conclusion:
Of the 6 records reviewed, 1 of the 6 had appropriate documentation for MMR (17%), and 3 of 6 had appropriate documentation for pertussis immunization (50%). Because of congregate living arrangements, significant underlying medical conditions, and the known re-emergence of preventable infectious diseases, including measles and pertussis, it is paramount that the Facility adhere to all CDC recommendations and guidelines for vaccination strategies. Appropriate CDC recommended proof of immunization is required. At the next review the Monitoring Team will look more closely at specific preventive health issues, such as screening for breast and prostate cancer.

<u>Chronic Care Conditions/Diabetes</u>
To assess the Facility's ability to manage chronic care conditions, the Monitoring Team reviewed all individuals with the diagnosis of diabetes mellitus (Individuals #150, #108, #85, #82, and #33). The Monitoring Team relied on the following core indicators to assess appropriate management: Comprehensive and specific IDT process that included physician services, nursing services, direct care support professionals, dietary, PT/OT, and psychology services); acceptable A1C, lipids profile, and urinalysis for proteinuria; annual ophthalmologic examination; and physical assessment that included evaluation for peripheral and autonomic neuropathy; foot evaluation; assessment of cardiovascular risk factors. The following table indicates whether appropriate management was evident.

Individual	Lipid	A1C	Prot	TSH	Eye	Pod	IDT	Card	Endo

#	Provision	Assessment of Status	Compliance

#150	X	X	X	X	X	NA	N	NA	X
#108	X	A	X	X	X	NA	N	NA	X
#85	X	X	X	X	X	NA	N	NA	X
#82	A	X	X	X	X	NA	N	NA	X
#33	X	X	N	X	X	X	N	N	NA

Individual: Individual's Report ID number
Lipid: Lipid studies
A1C: Hemoglobin A1C
Prot: Proteinuria assessment
Eye: Annual ophthalmologic examination
Pod: Annual podiatry evaluation, or documenting why not needed
IDT: Did an IDT that included psychology, nursing, medical, PT/OT, direct care professional, and dietary meet and specifically address management of Diabetes
Card: Comment on ischemic heart disease risk factors
Endo: Referred to endocrinologist (only essential if significantly uncontrolled)
X: Study was completed and normal
A: Study was completed but abnormal
N: Not assessed/completed
NA: Non applicable for this individual

Conclusion:
Individual #33 was reported by the Facility to have diabetes; however, upon review of the clinical record, the Monitoring Team noted that the individual does not have a diagnosis of diabetes, or meet criteria for diabetes, so Individual #33 will not be included in the analysis.

Of the remaining samples (Individuals #150, #108, #85, #82), 0 out of 4 (0%) included a comprehensive IDT discussion of diabetes by physician, nursing, direct support professional, dietary, and PT/OT; 4 out of 4 (100%) included necessary screening labs; 4 out of 4 included an annual optometry evaluation (100%); and although not necessary, 4 out of 4 (100%) were seen regularly by an endocrinologist; 3 out of 4 (75%) had excellent control of their blood sugars; 4 out of 4 (100%) had excellent control of kidney function; and 3 out of 4 (75%) had excellent control of their lipids.

The Monitoring Team would like to compliment the Facility for its excellent management of diabetes. It would be advantageous to ensure more robust involvement by the IDT process when addressing chronic health care issues, such as diabetes. The Facility must ensure accuracy when reporting on medical conditions.

#	Provision	Assessment of Status	Compliance
		Chronic Medical Conditions/Musculoskeletal-Neuromotor To assess the Management of chronic medical conditions, the Monitoring Team reviewed four cases of individuals who they observed as having orthopedic conditions (Individuals #115, #15, #61, #140). Individual #115 Monitoring Team's observation noted right hemiparesis, and abnormal gait. Review of clinical record indicated a diagnosis of cerebral palsy (CP), with right hemiparesis and equinic deformity of the right foot. Physician follow-up to care specific for orthopedic conditions was noted to very good. The physician appropriately documented the clinical condition and documented and executed an action plan that included PT/OT evaluation and referral to orthopedics for assessment. The PT/OT assessment was determined to be adequate; however, the recommendations were not sufficient. There was no documentation indicating that the IDT had addressed the orthopedic concerns comprehensively, and the ISP did not reflect the condition or necessary supports and services. Individual #15 The Monitoring Team noted Individual #15 to have visual impairment, in addition to a significantly abnormal gait. Clinic records indicate that the individual had a history of septic arthritis of the left knee that required surgery in the past. This is not represented in the ISP or Annual Medical Assessment. The Annual Medical Assessment and PT/OT reported no problems with gait. During the Morning Medical Meeting, the Monitoring Team raised the issue of a possible gait problem, and nursing staff corroborated that the individual's gait has deteriorated more recently. There was no indication of recent neuromotor or musculoskeletal diagnostics or consultations. Individual # 61 The Monitoring Team observed Individual #61 to have a significantly abnormal gait, with abnormally postured feet. Upon review of the clinical record, the Annual Medical Assessment, PT/OT, and ISP, indicated no problems with ambulation, extremities, but did comment pathological reflexes of the lower extremities. The ISP dated 9/6/11 documented a physician commenting on abnormal functioning of the individual's lower extremities, and a history of having an MRI of the spine. The Monitoring Team was not provided the MRI results for this review. The Monitoring Team determined that the individual has an abnormal gait, which has not been appropriately assessed, and the PT/OT assessment was inadequate, and did not represent what other health care professionals identified. Individual #140	

#	Provision	Assessment of Status	Compliance
		The Monitoring Team observed the individual to be in a Merry-Walker, noted to be wearing bilateral AFOs, had a significant forward leaning posture, and a severely abnormal gait. PT/OT assessments did not adequately represent the individual's condition, nor provide adequate recommendations to the physician. Review of the Medical History, dated 9/19/11, indicated that an MRI of the lumbar spine was completed and that there was minimal disc protrusion at levels L4-5. The Monitoring Team was not provided with a copy of the MRI report. An electromyography was completed on 2/11/11, that evaluated peripheral nerves only, and the report concluded that the individual had a "central etiology for gait compromise". Since then, there had been no further assessments, evaluation, diagnostics, or treatments for the individual's progressive functional decline. Review of the ISP indicates very limited participation by the IDT in evaluating and managing the individual's neuromotor condition. The Monitoring Team is concerned about the further deterioration in functioning of the individual, along with an MRI that demonstrated a central disc protrusion, which could progress over time, in addition to having an electrophysiological study that concluded that the individual's gait problems was because of a central process (spinal cord or brain). Review of this record leads the Monitoring Team to believe that a more comprehensive assessment and assertive treatment is needed to prevent progression of this Individual's condition. Conclusion: The Monitoring Team noted lack of a consistent and comprehensive approach to neuromotor, and musculoskeletal conditions; inadequate assessments and recommendations by PT/OT; lack of a well integrated IDT approach; deficiency and inadequate representation of such conditions in the ISP. <u>Chronic Care Conditions/Osteoporosis</u> To assess the Facility's ability to manage the diagnosis and treatment of Osteoporosis, the Monitoring team reviewed the clinical records of Individuals #69, #27, #91, #54, #8, #118, #98, and #4. The Facility was unable to provide the Monitoring Team with an accurate list of individuals who have a diagnosis of osteoporosis, osteopenia, or who was screened for low bone density. The following is a summary of findings, as related to the management of osteoporosis, for individuals reviewed:	

Individual	MED	ISP	PT/OT	LAB	ENDO	DEXA
#69	X	X	N	N	NA	X
#27	X	N	NA	NA	NA	X
#91	X	N	N	N	NA	X
#54	X	N	N	N	NA	X
#8	N	N	N	N	NA	N

#	Provision	Assessment of Status	Compliance

#118	N	N	N	N	NA	N
#98	N	N	N	N	NA	X
#4	N	N	N	N	N	X

Individual — Individual's Identification Number
MED — Was medical management appropriate
PSP — Did the PSP adequately reflect the condition and necessary supports and services
PT/OT — Did the PT/OT annual update adequately evaluate osteoporosis and make appropriate recommendations
LAB — Were laboratory test obtained to determine the underlying etiology of osteoporosis
ENDO — Was the Individual referred to an endocrinologist (not required)
DEXA — DEXA Scan
X — Completed and appropriate
N — Not completed
NA — Not applicable

Following are specific examples:
Individual #69
The individual was diagnosed with osteopenia and was treated with alendronate; however, the newly appointed physician appropriately discontinued the medication, while maintaining daily calcium and vitamin D therapy. The ISP reviewed the diagnosis of osteoporosis. PT/OT assessment did not review or comment on the issue of osteoporosis within the context of the PT/OT annual update. There was no clinical documentation to indicate that the etiology of osteoporosis was evaluated. It is exceptionally important that an evaluation for the cause of osteoporosis be sought prior to initiating treatment.

Individual #8
The individual had a DEXA report dated 4/8/09 that indicated that the individual was uncooperative with the test and the test was not completed. The individual was being treated with alendronate at osteopenia treatment dose, while diagnosed with osteoporosis. It was unclear to the Monitoring Team if the individual was osteoporotic, and required full treatment dose of alendronate, or if the individual was osteopenic and required preventive treatment. Importantly, the DEXA report that was provided to the Monitoring Team indicated that the test was not completed; hence, there is no accurate record of the individual's actual bone density.

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		Individual #118 The individual is known to have a history of very severe osteoporosis, with history of multiple fractures, including a hip fracture. The only DEXA report provided for review was from 10/05/04, which demonstrated severe osteoporosis. The Annual Medical Assessment provided for review, and completed by a physician who no longer works at the Facility, indicated that the individual was not osteoporotic any longer and discontinue medical treatment, and no further plan to assess. Individual #98 The Annual Medical Assessment did not indicate an action plan for osteoporosis. Individual #4 The action plan on the Annual Medical Assessment, dated 9/23/11, stated that the individual was to be referred for an endocrinology consultation to address her severe osteopenia, but no documentation was provided to indicate that the consult had been obtained or recommended treatment. The ISP did comment on Osteoporosis, but did not adequately reflect the condition, prognosis and necessary supports and services needed to manage this disorder. Conclusion: Of the 8 samples reviewed, 4 (50%), documented appropriate treatment and action plan specific for osteoporosis, 0 out of 8 (0%) had the condition well defined in the ISP, 0 out of 8 (0%) indicated appropriate assessment and recommendations by PT/OT, 0 out of 8 (0%) indicated appropriate assessment and understanding of the underlying cause of osteoporosis, and 6 out of 8 (75%) had appropriate bone density diagnostics. Osteoporosis is a serious medical condition that can result in worsening morbidity and early mortality. It is essential that before treatment, a search for the underlying medical condition is evaluated, and this was not done in any of the cases reviewed. PT/OT must integrate the diagnosis of osteoporosis in every action they recommend. PT/OT did not effectively integrate diagnosis into their assessments, or plan. The ISP must well represent this serious condition by documenting the current status of the condition, associated risks of treatment and no treatment, and necessary supports and services. The Monitoring Team incidentally noticed that for many people with an actual diagnosis of osteoporosis, the health risk assessment determined the individuals to have a medium risk for osteoporosis. Having the diagnosis of osteoporosis, and being treated for the condition, would place the individual at high risk, whereas a diagnosis of osteopenia should place the individual at medium risk of osteoporosis (perhaps higher depending on other risk factors such as family history or use of a medication with a side effect of loss of bone density). Importantly, the Facility did not have a mechanism to readily identify	

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		individuals who have been assessed or being treated for low bone density, nor does it have a process to screen individuals for osteoporosis. <u>Health Maintenance/Management of Syndromal Conditions</u> Syndromal conditions are commonly encountered within the context of developmental disability medicine. Facilities that provide clinical services must be well aware, and capable of assessing and managing such conditions. To assess the Facility's ability to address the management of syndromal conditions, the Monitoring Team request all laboratory studies, orthopedic consultations and diagnostics and cardiology consultations and diagnostic, the annual medical review, PT/OT assessments, and the ISP, for all individuals diagnosed with Down Syndrome. The Facility provided records for the three individuals diagnosed with Down Syndrome at the Facility (Individuals #126, #21, and #69). Individual #69 The individual's thyroid function was noted to be low on two occasions (TSH test on 1/30/12 was 7.04; 12/1/11 was 5.17). The most recent EKG, dated 7/29/08, was reported to be "borderline abnormal EKG possibly due to myocardial ischemia". No follow-up EKGs were noted in the clinical record, nor was a stress test considered. The individual did undergo an echocardiogram on 11/10/09, which was negative for structural abnormalities. The PT/OT annual assessment dated 10/06/11 was the only PT/OT document provided for review. The assessment reported that the individual had good strength and balance to learn advanced gait, however, the individual is not able to demonstrate advanced gait and needs assistance to stand unsupported with a single leg stance. PT/OT does not address the individuals known degenerative spine disease, which was diagnosed by x-ray on 10/29/09. The ISP dated 10/27/11 states that the individual "has no abnormalities with his gait or ambulation and requires no assistive devices"; "his gait has been stable and consistent"; "in order to avoid a risk to personal injury, a potential home should have a single story and leveled home". When assessing for physical environment, the ISP did not take into consideration PT/OTs assessment of not having an advanced gait, and requiring assistance to stand. The individual is known to have degenerative spine disease and arthritis, however, there is no process in place to regularly assess for possible pain. Review of the most recent Annual Medical Assessment, dated 11/11/11, noted an action plan for "degenerative disc at C2 and C3: Continue to follow." No further recommendations were made. Summary: There was no follow-up on abnormal EKGs; however, the individual was assessed for structural heart anomalies by echocardiogram. The PT/OT assessment was inadequate and misleading, and the ISP did not reflect issues related to Down Syndrome. The Annual	

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		Medical Assessment did not adequately address the individual's degenerative disc disease, and offered no specific pain management plan or assessment for this individual. Overall, there was no systematic approach to assessing health care maintenance issues specific for Down Syndrome. Individual #21 An EKG was obtained on 3/10/11, and was essentially normal. A Thyroid level (TSH), was obtained on 11/7/11, and was within normal limits. A complete blood count (CBC) was obtained on 5/12/11, and demonstrated macrocytosis (large red blood cells, which is common in people with Down Syndrome). The Physician followed up on the macrocytosis by obtaining a B12 and folate level, both of which were normal. No further follow-up or explanation was noted for the chronic macrocytosis. An x-ray of the cervical spine was obtained on 1/28/11 that demonstrated mild degenerative changes of the spine, however, the x-ray was not visualized well, and follow-up CT was recommended if the individual remained symptomatic. There was no follow-up on this limited spine x-ray. The individual was also noted to have a diagnosis of arthritis, however the location, and extent of the arthritis was not clearly evident by review of the clinical record. The Annual Medical Assessment commented on providing pain medication as needed for arthritic pain, however, there was no indication that a pain assessment was routinely assessed, specific for this individual. Review of the PT/OT Comprehensive Assessment Evaluation, dated 12/17/11, did not indicate important diagnosis such as arthritis and degenerative spine disease, and was determined by the Monitoring Team to be an inadequate evaluation. Summary: Recent screening CBC, TSH and EKG were noted in the record. Macrocytosis, which can be common in people with developmental disabilities was not completely assessed, or commented on by the physician. Abnormal C-spine x-ray and diagnosis of degenerative spine disease was not addressed in the medical action plan. The diagnosis and plan for arthritis was not comprehensively addressed. There was no specific pain management assessment initiated for this individual. The PT/OT assessment did not include important diagnosis, such as arthritis and degenerative spine disease, and provided an inadequate assessment and meaningless recommendations. There was no apparent systematic approach to assess health maintenance issues for individuals with Down Syndrome. Individual #126 The individual was noted to have extremely low functioning thyroid on 2/25/11, and supplemental thyroid hormone was initiated and levels were followed until they normalized. However, there was no assessment as to the etiology of the hypothyroidism. On 9/29/11, a peripheral blood smear was interpreted by a pathologist who noted no	

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		dysplastic cells, however, recommended trending analysis. On 11/6/11, and follow-up CBC demonstrated low red blood cell count and atypical lymphocytes, which were not present on the previous evaluation. Immature granulocytes, persistent low red blood cell count, and macrocytosis was evident on subsequent CBC studies. Also, on a CT of the spine, dated 12/26/11, an enlarged lymph node was observed in the cervical region. All of this suggests a possible and serious underlying hematologic condition that must be assertively assessed. PT/OT Annual Update, dated 6/1/11 lacked a meaningful physical assessment and no additional PT/OT assessments were identified. The individual does follow-up with a cardiologist for congenital endocardial cushion defect. The last EKG in the clinical record was from 2/26/11, and demonstrated sinus bradycardia. The individual was noted to have hypothyroidism, and was on thyroid hormone supplementation. The most recent thyroid test (TSH) was dated 2/25/12. There was no evidence demonstrating that the cause of the hypothyroidism was evaluated. The individual is known to have an abnormal gait, and underwent a CT of the neck on 12/26/11, however, the CT scan was inadequate because of motion artifact, and the radiologist recommended repeating the study. The Monitoring Team did not find evidence to support that the study was repeated, or corresponding rational for not proceeding with a follow-up study. Summary: The underlying etiology of the individual's hypothyroidism was not evaluated, and a possible hematologic condition was not fully assessed. The PT/OT assessments did not adequately assess the individual's physical condition, and follow-up on a radiologist recommendation to consider repeating a cervical spine CT scan, was not done. There was no evidence of a systematic approach to address the health maintenance issues for individuals with Down Syndrome. Conclusion: Following it's assessment of the Facility's ability to provide appropriate health maintenance for individuals with syndromal conditions, the Monitoring Team determined that the Facility did not have an organized, systematic approach to address routine health maintenance issues for people with Down Syndrome. As with all health maintenance programs, there are specific issues that must be regularly assessed in people with various syndromes, including Down Syndrome. The Facility should identify all known syndromal conditions that occur at the Facility, and develop specific health maintenance programs for each syndrome. <u>Focus Case Review</u> To assess the Facility's ability to address comprehensive management of individuals' healthcare issues, the Monitoring Team reviewed three clinical records,(Individuals #5, #13, and #29), based on clinical anomalies noted following the observational assessment	

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		of Individuals at their living area. The detail in these cases is provided to assist the Facility physicians as they continue their efforts to improve quality of care. Individual #5: The individual was suspected of having Prader Willi Syndrome. There did not appear to be an integrated approach by the IDT identifying Prader Willi as the central disorder for the individual's hypogonadism, obesity, hypotonic posture, scoliosis, diabetes, and many behavior manifestations, that are know to manifest in people with Prader Willi Syndrome. The IDT had not discussed the risk for metabolic syndrome, despite having diabetes, hyperlipidemia, significant abdominal girth, and administered Haldol and Seroquel. The Integrated risk rating dated 8/15/11 indicated only a medium rating for falls and fractures, despite having unsteady gait, osteoporosis of the spine, having to use a merry walker, and experiencing frequent falls. The Monitoring Team believes that such risk factors should result in a higher risk level. The Integrated Risk form did not indicate a risk for metabolic syndrome, although the individual was at significant risk. Importantly, there was no risk noted for the individual's recurrent right shoulder dislocation, which was evaluated by an orthopedic consultant who warned of life long risk for dislocation. Acute care issue dated 2/21/12, secondary to hypotension was attended to by the physician, and documented in SOAP format. The plan indicated that "will keep monitoring" for dizziness, however, there were no orders written, or other guidance for direct care staff to monitor for dizziness. Acute care issue dated 2/15/12, secondary to a fall indicated in the plan that "long history of gait ataxia", and "long history of needing gait aid" so "at this point I will ask PT to review and reassess merry walker". The Monitoring Team was unable to identify documentation indicating a comprehensive evaluation for the individual's noted ataxia, and worsening falls. A post surgical assessment by the physician on 1/30/12, was well documented in SOAP format, however, the Monitoring Team could not identify documentation where the physician followed this issue to resolution. Of significant concern is that the IDT was not made aware of the seriousness of the individual's severe blood clotting abnormality. It is critically important that the this clinical issue be well delineated within the context of the Personal Support Plan (ISP), and that all staff be clearly made aware of what should be done following a physical trauma, dental and medical procedures, or when the individual starts to bleed. This issue should also be well documented on the health risk screening form.	

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		Summary: Specific to acute care management, in general, the individual was promptly assessed by the physician, and appropriate medical treatment was provided. Provision of care, however, was not conducted through a meaningful IDT process. Importantly, the Monitoring Team noted that assessment of the individual's chronic health care issues, including, but not limited to severely worsening abnormal gait, blood clotting disorder, and health risk screening, was inadequate. Individual #29 The individual was noted to have a significant gait abnormality, and was provided 1 to 1 supervision to assist in guiding the individual. The individual was known to have limited vision, and contracture of the left leg, has experienced multiple fractures in the past that include fractures of the ribs, and poorly healed fracture of the patella, is diagnosed with osteoporosis, and has a significant and recent history of falls. Importantly, the individual has multiple and serious other medical diagnosis, which included heart valve disease, pulmonary hypertension, urinary bladder distention, and other disorders. Despite excellent medical follow-up on many of his serious medical conditions, such as his heart disease, there was no comprehensive medical follow-up on the individual's abnormal gait or cause of his abnormal gait. The Monitoring Team noted the individual on two different occasions to have an abnormal posture, and gait. The Monitoring Team could not identify in the clinical record that an orthopedic or related consultation had been obtained. During morning report, emphasis was placed on the individual's poor eyesight as the cause for his falls. Nurses during the meeting concurred with the Monitoring Team that the individual's gait had changed. A CT scan report of the abdomen and pelvis, dated 12/29/11, was observed to be in the clinical record. The report was signed by the physician, however, there was no corresponding note by the physician addressing degenerative changes in the spine, atrophic left kidney, and cystic, hypertrophic appearing right kidney, and surgically absent gallbladder. Abnormal findings on a sonogram of the bladder, dated 2/14/12, was commented on a physician note dated 2/15/12; however there was no plan as to how to follow-up or documentation of a differential diagnosis. A modified barium swallow was obtained because of concerns of dysphagia. The physician signed the report, dated 11/7/11; however, there was no corresponding note commenting on the results and necessary action plan for laryngeal penetration.	

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		The Health Risk Screen, dated January 13, 2012, indicated a medium risk for falls, and no risk factor of poor vision. The Monitoring Team noted the significant fall history, visual problems, diagnosis of osteoporosis and severe gait abnormality. The Monitoring Team determined that there should be a high risk for visual impairment, and fracture risks. In general, after reviewing the individual's recent ISP, the Monitoring Team noted improvement with integrating health care issues into the ISP; however, many health care issues, such as worsening gait and visual issues, were not adequately reviewed by the IDT or documented within the ISP. Summary: This case clearly demonstrates the marked improvements in health care at the Facility. The medical follow-up for many of the individual's serious medical conditions, such as heart disease, were appropriately addressed by the medical staff. Documentation by the physician on a recent hospitalization demonstrated comprehensive follow-up by medical staff. The individual's abnormal gait was not assertively assessed, as a component of the individual's increased fall risk. The health risk screening report lacked meaningful assessment for fracture risk and did not indicate poor vision as a risk. Follow-up on abnormal diagnostics has improved; however, further improvement is necessary. Individual #80 The individual was diagnosed by CT with moderate to severe degenerative cervical spine disease. His consulting neurologist corroborated this diagnosis. There is no documentation to demonstrate assertive monitoring for pain, discomfort, or neurological progression was offered by the Facility. This condition is often very painful and can lead to maladaptive behaviors. Degenerative spine disease is a progressive condition that may lead to serious neurologic compromise, serious behavior problems, increased morbidity and mortality. The ISP dated 1/27/12 commented that the individual required a hospital bed and the need to purchase a cervical pillow because "he has been diagnosed with stenosis of the neck and may have pain." No scheduled pain medications were provided; however, it was reported that when staff report pain, prn medications would be provided. During the morning medical meeting, it was reported that the individual was able to ambulate without assistance; however, the Monitoring Team observed the individual for 30 minutes on February 28, 2012, and on February 29th, 2012, during which time, the individual required maximum 1:1 support, with a lift vest, to help direct and support the individual from falling. The individual was noted to have a significant scissor gait. Importantly, the Monitoring Team had noted significant worsening of gait from the prior Monitoring Team visit. In addition, the Monitoring Team noted that the individual had a large indurated lesion on his forehead that is erythematous, and is reported to be secondary to the individual's self-injurious behavior of head banging. The Monitoring Team observed the individual hitting at his neck. The	

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		individual had, in recent years, experienced many fractures, including fractures of the left tibia and fibula, right femur, and multiple rib fractures. The individual was also noted to have high intensity signal of cervical spine C3, and C4, which is suggestive of boney injury. The Monitoring Team noted a neurosurgeon's recommendation for spine surgery to correct the individual's moderate to severe degenerative spine disease. A second opinion by a different neurosurgeon suggested not to proceeding with spine surgery, however, that surgeon did not document findings from a previous CT of the spine, which demonstrated moderate to severe degenerative changes, with cord and root impingement, nor was he made aware of significant changes with the individual's ability to ambulate. The discrepancy of these reports was not document in the clinical record, nor was there documentation that the IDT was well informed of the clinical issue. Review of physical and occupational therapy assessments (PT/OT) did not clearly document the individual's overall functional decline, with regard to worsening gait. The assessment was determined to be inadequate by the Monitoring Team. The individual was determined to be appropriate for a move to a more integrated setting, which was schedule to occur within one week from the date of the Monitoring Teams on-site review. There was no updated medical evaluation provided yet for the Community Living Discharge Planning documents indicating the seriousness of the individual's underlying spine disease. The Monitoring Team shared with administrative and medical leadership its serious concern about the need for a more comprehensive identification of needed supports for community living to address the individual's current medical condition and ensure the provider was fully aware of the significance and need for supports related to this condition, Summary: The Monitoring Team determined that the physician did not complete a comprehensive assessment of gait abnormality and fall risk and that necessary supports and services were not developed or implemented in an integrated way. PT/OT services did not adequately assess, treat, or report on the individual's very serious gait abnormality and degenerative spine disease. The Monitoring Team was especially concerned with the lack of comprehensive identification of needed supports for community living on the part of the IDT for the move to a more integrated setting. Integration of the individual's health care issues were noted to be inadequate. Conclusion: The Monitoring Team clearly identified significant improvement in quality and comprehensiveness of medical care of individuals residing at the Facility. Improved	

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		documentation practice and follow-up to acute medical problems was clearly evident upon review of the three cases. Although there is much better representation of medical issues noted within the ISPs, a more integrated approach to health care management is needed. Importantly, neuromotor and musculoskeletal conditions must be more assertively managed by the Facility. Of the three cases reviewed, 0 out of 3 cases demonstrated comprehensive, well-integrated clinical management (0%). The Facility does not appear to provide regularly scheduled assessments for the management of chronic conditions. <u>Individuals Identified as Requiring a Do Not Resuscitate Order (DNR)</u> The Monitoring Team was informed that there were no individuals who were assigned a DNR order, nor were individuals systematically assessed for the possible benefit of a DNR order. Standard of care practice requires appropriate assessment for DNRs. All individuals should be assessed for a DNR, and the Interdisciplinary Team (IDT), that includes the Legally Authorized Representative (LAR), and the individual, should determine assignment of a DNR order or not assign a DNR order. DNRs should be considered when the risk of performing chest compressions outweighs possible benefits, and also when there is a diagnosed end of life conditions that is irreversible. DNR orders should only be prescribed in accordance with Texas law. It is also important to recognize that a DNR order is not to be construed as with holding of treatment Conclusion: The Monitoring Team recommends that the Facility develop a mechanism that ensures individuals who may benefit from a DNR are identified, and that the clinical rationale and risk-benefits of a DNR order are explained to the IDT, which includes the LAR and individual served. Summary of Provision L1 Overall, the provision of medical services has significantly improved. Physicians are appropriately and promptly addressing acute medical issues, hospital follow-up care, documentation practice, management of complicated chronic conditions, are all areas of significance. In general, individual are medically triaged appropriately and the physician staff has demonstrated very good clinical management. The Facility recognizes that it still has many obstacles to overcome, and must better address certain conditions that are common to individuals with developmental disabilities, improving on its immunization strategy, integrating health care issues into the team process, and developing a functional, and accurate management system for clinical data, which will enable real time reports such as current diagnosis, updated problem lists, and enable rapid the query of clinical data elements, such as providing a physician with an accurate flection of current A1C values. The Monitoring Team concludes that the Facility in not in compliance with Provision L.1.	

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L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	To assess compliance for Provision L2, the Monitoring Team reviewed all physician review processes conducted by the Facility. <u>Physician Audits</u> The Facility reports participating in two medical review processes. The Facility had participated in round 2 of the DADS Medical Provider Quality Assurance Audit, in August of 2011, which consists of non-facility physicians conducting case reviews of the Facility's physicians. The results of the audit were not shared with the Facility's Physicians and action plans for deficiencies were not developed. Results from the audit were well below the compliance threshold for both essential and non-essential issues. The Monitoring Team was informed that the audit did not take into consideration the fact that newly hired physicians were just recently assigned caseloads, which were then used to judge their compliance, and not the physician who actually provided service. The Facility also participates in its own audit process, whereby a local, but not Facility physician, conducts a similar Medical Provider Quality Assurance Audit, by utilizing the same tool as the DADS process. The Facility last participated in its own audit in October, but will start the process again in April. No results of the past internal audits were made available for review. <u>Mortality Review</u> There were no deaths to review Conclusion: The Facility has not effectively implemented the State's Medical Provider Quality Assurance Audit process. In addition, there is some concern that external physician reviewers that conduct these reviews did not accurately identify outcomes based on the work completed by the reviewed physician, and did not take into consideration the work of other physicians who perform activity within the clinical record, which could be misleading. Also, the Facility has developed its own process for conducting internal reviews, to help them prepare for the State Audits. This process, however, does not have a written procedure, nor has it been functional to date. For these reason, the Monitoring Team determined that the Facility is not in compliance with Provision L2. Compliance will require adherence to DADS State Policy for External Audits (including developing corrective action plans), and enhancing the DADS Medical Provider Quality Assurance Audit by including a robust clinical performance component, to assess the clinical abilities of physicians.	Noncompliance
L3	Commencing within six months of the Effective Date hereof and with	To assess compliance of Provision L.3, the Monitoring Team requested all local policies and procedures specific to the provision of medical services.	Noncompliance

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	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 Facility had not developed a process to conduct quality assurance review to assess the Facility's overall management of medical care. The Facility reported that they will begin developing a QA process in the near future. There were no documents to review for this section. <u>Conclusion:</u> Because the Facility had not implement a QA process for medical care, the Monitoring Team determined that the Facility is not in compliance with Provision L.3. The Facility must develop and implement a meaningful QA medical review process to assess clinical outcomes and ensure the provision of medical care meets or exceeds generally accepted standard of care practices. The process must include a mechanism to collect, store and conduct longitudinal trends analysis of clinical care.	
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.	To assess appropriateness of medical related policies and procedures, the Monitoring Team request all implemented clinical related policies and procedures, and a copy of the DADS State Office Clinical Pathways that they have implemented. <u>Clinical Pathways</u> The Monitoring Team was not provided with copies of Clinical Pathways to review. Comments made by physicians regarding Clinical Pathways, indicated that they were confusing, too long, and not in a standardized format. The Monitoring Team's recent review of Clinical Pathways on diabetes, pneumonia and osteoporosis at an alternate Facility, corroborates the physicians concerns. For Clinical Pathways to be functional, they should: Be concise, all share a similar format, provide relevant details specific to the unique issues and challenges for individuals with developmental disabilities, and they should delineate involvement of the IDT. <u>Standard Operating Procedure, ICF-MR 400-14, dated December 9, 2010</u> Upon review of the Standard Operating Procedure, the Monitoring noted many areas of concern. First, clinicians did not implement most of the procedures outlined. For example, Procedure I.A states that the clinical care and treatment is provided in an integrated manner as clinically indicated. The Monitoring Team noted many examples of limited or no team integration of health care issues. Procedure I.B states that the QMRP will ensure that the PCP is invited to all PST/A, Quarterly and Special staffing as clinically indicated, and based upon individual's preferences. In this example, the Monitoring Team noted many examples where physicians' representation in the IDT process was limited. The Facility did not have a procedure to ensure that relevant clinical issues are well communicated to and from the physician, in the event that the physician does not physically attend the ISP planning meeting or other IDT meetings. Section I.G states that	Noncompliance

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		at least quarterly, all active and chronic problems will be reviewed; however, chronic conditions were not being assessed quarterly. Importantly, depending on the clinical issues, physical evaluations may be required more frequently, based on standard of care practice. <u>Preventive Health Care Guidelines, dated August 30, 2011</u> The Monitoring Team noted that the Facility did not have specific health risk screening procedures for syndromal conditions. Many syndromes manifest secondary conditions that must be routinely monitored for. Examples would be musculoskeletal problems, hematological conditions, thyroid dysfunction and dementia in individuals diagnosed with Down Syndrome. Also, many people with developmental disabilities develop low bone density at a very early age, and young men are equally at risk. The Facility's policy for screening of osteoporosis limits screening to women who are 65 years or older, or younger women who have a fracture risk equal to that of a 65 year old women. The Monitoring Team is aware that many risk factors, including sedentary lifestyle, limited ability to participate in physical activities, exposure to certain medications, limited sun exposure, and some developmental conditions, place all adults, of all ages, at risk for low bone density, hence screening must be individualized and be inclusive, regardless of age and sex. The Facility did not have a procedure for managing issues related to challenges with compliance, and physical attributes that may place individuals more at risk by undergoing the screening process. For example, one must consider the risks and benefits of screening for cervical cancer if the individual requires anesthesia for the procedure. Conclusion: The Monitoring Team determined that the medical policies, and procedures provided for review were either not implemented at the Facility, or were inadequate. For these reasons, the Monitoring Team determined that the Facility is not in compliance with Provision L.4. Compliance will require careful review of all clinical policies, and procedures, ensure that they are fully implemented, and ensure that they are appropriate for providing health care to individuals with developmental disabilities.	

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

1. Enable CME opportunities for issues related to developmental disabilities, such as Cerebral Palsy, dysphagia, chronic constipation and bowel obstruction, spasticity, and dystonia. (Provision L1)
2. Ensure that individuals are being appropriately assessed for potential DNR status. (Provision L1)
3. Immediately enhance the immunization process to ensure that individuals either meet or exceed CDC recommendations for immunization, and that immunization records reflect CDC guidelines. (Provision L1)
4. The Facility must enhance its IDT process for addressing medical issues. This is especially important for serious acute and chronic conditions. The

ISP must adequately reflect the condition, its risks and benefit of treatment, versus no treatment, prognosis, and all necessary supports and services. (Provision L1)

5. When clinically appropriate, develop a mechanism to review chronic conditions more frequently. (Provision L1)
6. The Facility must immediately develop procedures to improve on the management of neuromotor, and musculoskeletal conditions. (Provision L1)
7. Better address health maintenance issues regarding known syndromal conditions at the Facility, such as Down Syndrome. (Provision L1)
8. PT/OT must improve on assessments and recommendations. (Provision L1)
9. The Facility must develop a mechanism to manage clinical data elements that will provide real-time, and accurate diagnosis and problem list, and enable the query of clinical data. (Provision L1)
10. Develop a mechanism to appropriately screen individuals for osteoporosis. (Provision L1)
11. Ensure that secondary causes of osteoporosis are evaluated before starting medical therapy for osteoporosis. (Provision L1)
12. PT/OT must include their consideration of the diagnosis of osteoporosis when assessing individuals, and consider the diagnosis when making recommendations. (Provision L1)
13. Implement the Medical Provider Quality Assurance Audit process. (Provision L2)
14. Develop a procedure for the Facility's internal audit process, and ensure compliance. (Provision L2)
15. Ensure that Medical Provider Quality Assurance Audits reflect performance of the physician being audited, and not the work of other physicians that may be included in the records the reviewed physician. (Provision L3)
16. Enhance the State Medical Provider Quality Assurance Audit to include a robust clinical performance review. (Provision L3)
17. Carefully review all clinical policies, and procedures, ensure that they are fully implemented, and ensure that they are appropriate for providing health care to individuals with developmental disabilities. (Provision L4)
18. Make effort to ensure Clinical Pathways are concise, share a similar format, provide relevant details specific to the unique issues, and challenges for individuals with developmental disabilities, and they should delineate involvement of the IDT. (Provision L4)

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 Self-Assessment, updated 2/13/12 2. RGSC Presentation Book for Section M 3. RGSC Medical Emergency Response Policy, Date Established: 9/13/10, Revised: 9/22/11 4. RGSC Oral Pharyngeal and Nasopharyngeal Suctioning, Date Established: 12/2003, Revised: 2/2011 5. RGSC Occult Blood Testing and Collection, Standard Operating Procedure NR 400-48, Date Established 9/2011 6. RGSC Suction Machine Guidelines, no date 7. RGSC Nursing Protocol Cards for Antibiotic Therapy, Vomiting, Respiratory Distress/Aspiration, Pre-Treatment and Post-Sedation, Diarrhea, Temperature Elevations, Constipation, Head Injury, and When Contacting the Primary Care Physician (PCP), no date 8. RGSC Nursing Assessment in Acute Situations, Standard Operating Procedure NR 200-30, Date Established: 12/1998 (not reviewed or revised since established) 9. RGSC Communication with Hospitals and other Acute Care Facilities, Standard Operating Procedure NR 400-46, Date Established: 8/2009, Revised: 10/2011 10. RGSC Medication Error Policy, Standard Operating Procedure NR 400-12, Date Established: 9/1998, Revised 2/2011 11. RGSC Organizational Chart for the Nursing Department 12. RGSC List of Budgeted Nursing Staff for Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) 13. RGSC Nursing Services Overtime Report, 8/2011 through 1/2012 14. RGSC Nursing Staffing Analysis Summary, July, 2011 through December, 2011 15. RGSC List of Nurse Managers' Caseload 16. RGSC Nursing Services Overtime Hours Report, 8/2011 through 1/2012 17. RGSC Schedule of Nursing Meetings, 2/27/12 and 3/1/12 18. RGSC Nursing Meeting Minutes, 9/8/11 through 1/12/12 19. RGSC Nursing 24 Hour Reports for the past six days 20. RGSC Blank Hospital Transfer Form, 6/2011 21. RGSC Blank Hospital Liaison Report, 6/2011 22. RGSC Blank Hospital Report Worksheet, 8/2009 23. RGSC Blank Memorandum of Transfer, Revised: 2/27/96 24. RGSC Blank Records Verification Checklist for Hospitalization, 8/2009 25. RGSC Nursing Departmental Indicators for Quality Improvement First Quarter (September, October, and November) 2011 26. RGSC Nursing Auditing/Monitoring Activities, Nursing Analysis Reports, and associated Plans of Correction for the past six months for the following: • Insulin Administration • Nursing Assessment Completion/Authentication • 24 Chart Checks Review of Orders

	• Monthly Consultation Audits 27. Health and Human Services Enterprise Nursing Position Descriptions: Nursing Operating Officer/Hospital Liaison, Nurse Educator/Infection Control Nurse 28. RGSC Nurse Educator: Course and Instructor Evaluation Form 29. RGSC Nursing Schedule Competencies for Calendar Year 2012 30. RGSC Nursing Competency Training Report and Data for 2/2012 31. RGSC Nurse Training Report by Course and Percentage of Completion and Signed Training Records, 9/1/11 through 1/27/12 32. RGSC Safety/Risk Management/Infection Control Committee Minutes, 8/2011, 9/2011, 10/2011, 11/2011, 12/2011, and 1/2012 33. RGSC Nursing Glucometer Compliance, no date 34. RGSC Medication Administration Observation Process 35. RGSC Medication Administration Observation Quarterly Schedule, 2012 36. RGSC Medication Administration Observations and CATW2 Reports, 1/2012 and 2/2012 37. RGSC Medication Management Processes, Annual Evaluation FY 2011: Section 1.0: Medication Management (MM.01.01.01, MM 01.01.03, MM.06.01.05) 38. RGSC Blank Medication Variance Report Form 39. RGSC Medication Management Workgroup Notes, 11/29/11, 12/27/11, and 1/24/12 40. RGSC Pharmacy and Therapeutic Sub-Committee Meeting Minutes 9/14/11 and 12/21/11 41. RGSC Infectious/Contagious Disease Report, First Quarter FY 2012 and Second Quarter FY 2012 42. RGSC Mock Medical Emergency Checklist Analysis Summary, 7/2011 through 12/2011 43. RGSC A list of where Medical Emergency Equipment and Automated External Defibrillators (AEDs) are located within the Facility 44. RGSC Mock Medical Emergency Drill Reports and Corrective Action Plans, 9/2011 through 12/2011 45. RGSC Emergency Equipment Walk-through Checklist Form 46. RGSC Emergency Oxygen Tank and Suction Machine Checklist 47. RGSC AED Check-Off Sheet 48. RGSC Emergency Drill Instructor Training, Emergency Drills, 044.2 Emergency Response Policy 49. RGSC Emergency Drill Instructor Competency Exam 50. RGSC Emergency Drill Instructor Training/Course Sign-in Sheet for Instructors Trained, 3/1/12 51. RGSC List of Staff Delinquent in Training on Basic CPR and CPR for Healthcare Providers, 1/31/12 52. RGSC Completed Mock Medical Emergency Drill Sheet, 3/1/12 53. RGSC Medical Emergency Checklist Analysis Summary for past six months 54. RGSC Completed Emergency Oxygen Tanks and Suction Machines, AED, Emergency Equipment, and Environmental Checklists, for Vocational Services, La Paloma and El Paisano, 1/2012 and 2/2012 55. RGSC H and H Golf Carts and outdoor Power Quote, 10/12/11 56. RGSC List of Serious Injuries, 9/11/11 through 12/21/11 57. RGSC Environment of Care Manual Surveillance, Prevention and Control of Infection Manual, Revised 11/2011 58. RGSC Cleaning, Disinfection and Sterilization Flowchart, 3/2009 59. RGSC Comprehensive Preventative Health Database, 3/2011 through 8/2011 60. RGSC Infection Control Review, 2/2012

	61. RGSC Infection Control Investigations, 2/2012 62. RGSC Evaluation of the Infection Prevention and Control Plan Annual Report (IC 03.01.01) 63. RGSC Infection Control Departmental Performance Measures, Fiscal Year 2012 64. RGSC Performance Measure 10A: Data on Healthcare Associated Infections according to CDC categories 65. Dallas County Health and Human Services, County-wide 2009 Antibiogram and Susceptibility of Common Organisms, 8/2009 66. RGSC Employee Health Departmental Performance Measures, Fiscal Year 2012 67. RGSC Competency Training and Development (CTD) Course Participation Report for Infection Control, 1/30/2012 68. RGSC List of Individuals with Active Infections at the time of the review 69. RGSC Percentage of Individuals Current with Tuberculosis Skin Test 70. RGSC Percentage of Individuals Current with Seasonal Flu Vaccinations 71. RGSC Medication Administration Observation Process 72. RGSC Medication Administration Observation Schedule FY 2012 73. RGSC Medication Administration Observation Reports, 9/2011 through 12/2011 74. RGSC Medication Error Trend Analysis, FY 2011 75. RGSC List of At Risk Individuals, 1/25/12 76. RGSC List of Individuals seen in the Emergency Room and/or were Hospitalized within the past six months 77. RGSC List of Individuals recently diagnosed with Pneumonia 78. Records Reviewed for Individuals: #33, #149, #47, #80, #13, #134, #108, #79, #98, 127, #29, #97, #4, #54, #149, and #5 **People Interviewed:** 1. Yolanda Gonzalez, RN Chief Nurse Executive (CNE) 2. Nadia Noriega, RN Unit Nurse Manager (UNM) 3. Albert Lee Weaver, RN, Nurse Educator 4. Amor Escalona, RN, Nurse Case Manager (NCM) 5. Susana Garcia, RN, NCM 6. Lilia Gutierrez, RN, NCM 7. Angela Jones, RN, NCM 8. Yesi Garcia, Clerk IV 9. Belinda Guevara, Medical Hospital Liaison Clerk 10. Jessica Juarez, RN, Infection Control Preventionist (ICP) 11. Michael Robinson, RN, Quality Assurance Nurse (QA) 12. Maria Dill, MD, Medical Services 13. Catherine Cavazos, RN, Employee Health 14. Lorraine Hinrichs, ICF-DD Program Director 15. Ray Ramos, Risk Manager Supervisor 16. Ricky Zuniga, Interim Vocational Services Manager 17. Numerous Staff Nurses and Direct Care Professionals **Meeting Attended/Observations:** 1. Review of Section M Presentation Book with Nursing Administration, 2/27/12

	2. Infection Control Program Staff, 2/27/12 3. Morning Medical Meeting, 2/28/12 4. Medication Administration Observations and Tour of La Paloma and El Paisano, at 4:00 p.m. 2/28/12 5. Luis Lester, Contract Pharmacist, Anne Ikponmwonba, In-Patient Pharmacist, and Dr. Moron, 2/29/12 6. Mock Medical Emergency Drill at Vocational Services, 3/1/12 7. Personal Support Team Meeting for Individual #97, 3/1/12
	Facility Self-Assessment: The Facility's Self-Assessment, updated 2/13/12, provided comments regarding Sections M.1 through M.6 of the Settlement Agreement. The Facility indicated it was not in compliance with Provisions M.1 through M.6, and the Monitoring agreed with their assessment. The Facility's Self-Assessment Report included the activities the Facility engaged in to conduct the self-assessment, data to represent the results, and self-ratings based on the findings. The Facility described the methodology used for rating each provision. The data used to determine assessment ratings consisted primarily of the scores derived from the percentage of compliance achieved through the results of various monitoring tools, tracking and trending of reports generated though various committees, and training activities. An Action Plan that accompanied the Self-Assessment listed action steps for each provision to guide the Facility through substantial compliance with each provision. The action steps primarily related to content from previous reports or specific recommendations made by the Monitoring Team. The actions did not reflect a comprehensive strategic action plan to adequately guide the Facility through the process of achieving compliance across all provisions. The Facility should go beyond the content found in previous reviews and the Monitoring Team's recommendations, and consider forward thinking when developing future action steps directed at achieving compliance with all the requirements set forth in each provision. Simply relying on previous report findings and the Monitoring Team's previous recommendations will not significantly move the Facility forward in achieving full compliance with each provision.
	Summary of Monitor's Assessment: **Provision M.1:** This provision was determined not to be in compliance. The Nursing Department needs to improve assessment, management documentation, and follow-up through to resolution of individuals' acute changes in status. **Provision M.2:** This provision was determined not to be in compliance. The Nursing Department needs to improve the comprehensiveness and quality of nursing assessments related to individuals' high and medium risk ratings, as well as active medical problems for which nurses are responsible for providing care. **Provision M.3:** This provision was determined not to be in compliance. The Nursing Department needs to individualize Health Maintenance Plans (HMPs) and Acute Care Plans (ACPs) to meet each individual's specific health care needs in relation to their identified risk ratings and active medical problems for which

	nurses are responsible for providing care. Often individuals' high and medium risk ratings and active medical problems for which nurses were responsible did not have a nursing diagnosis/problems listed or a HMP developed. Conversely, HMPs were found that did not have an adequate nursing diagnosis/problem corresponding to the HMP. A review of records found that many acute changes in status that required nursing interventions did not have ACPs developed and implemented. The ACPs reviewed found no supporting documentation in the active medical record that the nursing interventions described in the plans were carried out. Neither were the ACPs individualized to adequately address individuals' specific acute changes in status. **Provision M.4:** This provision was determined not to be in compliance. Although improvements were found relating to nursing training on established policies, procedures, and protocols with the addition of a full time Nurse Educator, there was no evidence that the nursing staff were translating the training into actual nursing practices. In order to meet compliance with this provision the established policies, procedures, and protocol must be demonstrated consistently through actual nursing practices. **Provision M.5:** This provision was determined not to be in compliance. A risk process was in place; however, there continued to be a lack of critical thinking when the interdisciplinary teams moved beyond the risk guidelines. Individuals were not consistently provided with adequate comprehensive assessments in response to acute changes in status or as part of annual assessments. Risk Action Plans did not consistently include measureable, observable, and realistic objectives for each action step to evaluate the effectiveness of the plan. Clinical indicators were not consistently included for each risk rating. The plans failed to include action steps for all relevant disciplines **Provision M.6:** This provision was determined not to be in compliance. The Facility had not adopted and implemented the Department of Aging and Disability Services, Medication Variance Policy, 053. Only the Medication Variance Report form was implemented. This policy addresses all aspects of medication variances that the Facility was not considering in their medication administration practices. The nursing staff continued to split tablets to make the required decrease of medications that were not dispensed by the pharmacy. The pharmacy reported they were prohibited from splitting tablets to make the correct dosage. Further, the Pharmacy and Therapeutics Sub-Committee gave approval for the nurses to continue to split tables. The practice of requiring nurses to split tablets to make the correct decreased dosage is not in keeping with generally accepted medication administration practices. The State Office Pharmacy Coordinator and other relevant State Office Administrative staff should address this issue. The Facility continued to use a duplicate system for documenting medication administration, e.g., the MediMar and paper MARs. Having duplication increases the time it takes to administer medication and the potential to cause medication errors. While the nursing staff had general knowledge of dysphagia, they lacked the knowledge to fully understand and implement strategies related to PNM. The nursing staff administering medication needs additional dysphagia training in order to ensure that medications are administered safely to prevent aspiration. The findings relating to noncompliance are discussed in detail in each of the Provisions, as well as the accompanying recommendations. The Facility should not limit their action plans to the findings and

	recommendations contained in the report. Rather, the Facility should exercise forward thinking in developing and implementing action plans for all requirements contained in Section M's Provisions of the Settlement Agreement.

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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.	This provision of the Settlement Agreement includes a number of requirements that address various areas of compliance. These requirements include: staffing, quality assurance efforts, assessment and documentation of individuals with acute changes in status, availability of pertinent medical records, infection control, and mock medical drills and emergency response system. Additional information regarding the nursing assessment and development and implementation of health care plans is found below in Provision M.2 and M.3 report. Information and recommendations regarding nursing documentation regarding restraints is included above in Sections C.5 and C.6 of the report. The Facility's Section M Self-Assessment stated they were not in compliance with this provision and the Monitoring Team concurs, although through review of Section M Self-Assessment, Section M Presentation Book, staff interviews and review of documents, there was evidence that the Nursing Department had continued to make some improvements toward achieving compliance in all of the various requirements contained in this provision. <u>Staffing</u> At the time of the review the Facility was providing services to 70 individuals. The Nursing Department had 21 budgeted nursing positions, of which there were 13 RNs and eight LVNs. One RN and one LVN position was vacant. Since the last review several changes were made to the organization and structure of the Nursing Department. It was positive to find the Nursing Department had hired a full-time Nurse Educator. One of the Unit Nurse Managers had transferred to the Habilitation Department to serve as a Physical and Nutritional Management (PNM) Nurse. According to the CNE this Unit Nurse Manager position will not be filled because the State Office Nurse Coordinator told her that a census of 70 did not qualify for an additional Unit Nurse Manager. The other Unit Nurse Manager position was vacated when the nurse took the position as the Nurse Educator. A new Unit Nurse Manager was recently hired to serve as the Unit Nurse Manager for both La Paloma and El Paisano. The Nurse Case Manager system was fully implemented with four Nurse Case Managers. Each Nurse Case Manager had a caseload ranging from eight to 22 individuals based on levels of acuity. Nurse Case Managers work schedule had been changed to work from 8:00 a.m. to 5:00 p.m. Monday through Friday in order improve their focus on case	Noncompliance

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		management responsibilities. This change eliminated the need for the Nurse Case Managers to provide staffing nursing coverage; which had interfered with their case management responsibilities. It was also positive to find that recently the Nurse Case Managers were paired with the Qualified Developmental Disability Professionals (QDDPs) who had the same caseload of individuals. In addition, the Nurse Case Managers share office space with their respective QDDPs. In general, this has enhanced communication and collaboration regarding individuals on their mutual caseloads, leading to more integration of services with the respective QDDPs and Interdisciplinary Teams (IDTs). Another change that occurred since the last review included the move of the Quality Assurance Nurse into the Infection Control Nurse position. A new Quality Assurance Nurse was hired who began employment the first day of the Monitoring Team's review. Additionally, the Facility had made arrangements with the Valley Baptist Hospital for a Phlebotomist to draw blood for laboratory testing, thus relieving the Facility nurses from this responsibility. The Nursing Department continued the relationship with Texas State Technical Collage, School of Nursing, for clinical rotations of their LVN Nursing students. Most, if not all, of the students were licensed LVNs who were ready to perform "hands on" clinical work under the supervision of an instructor. RN students will be added to the rotation once the Fall semester starts. This relationship has the potential to serve as a recruitment tool for employing newly graduated RNs, as well as providing specialized training in Intellectual/Developmental Disability Nursing. 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 four agency nurses. Although there had been some improvements made, this sub-section of the provision was not found in compliance; the Facility should maintain the positive practices identified in the report and make improvements on the following practices: • The Nursing Department should ensure that the recently hired Infection Control Nurse, Unit Nurse Manager, and Nurse Educator are thoroughly trained and demonstrate competency in their respective roles and responsibilities. <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	

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		way to gain a clear and comprehensive picture of individuals' clinical status. This posed a barrier when integrating clinical data into a useful manner. While completing record reviews on the Integrated Progress Notes related to nursing care, each entry had to be accessed and aggregated together. It was not functionally practical to access chronological 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. The physicians did not document their progress notes in CWS. For the Integrated Progress Notes in the CWS system to be useful for integrating clinical 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. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Since the last review, no significant improvement was found in the assessment and documentation of individuals with acute changes in status. Some of the deficits in nurses' clinical competency to provide adequate nursing care for acute conditions, were validated in review of clinical records for the past six months. A review of records found the same problematic issue identified in past reviews. Records were reviewed for Individuals #33, #47, #80, #134, #108, #79, #98, #29, #127, #5, #4, and #13. The findings included: • The revised 24-Hour Nursing Report did not consistently include pertinent information for the nursing staff to follow upon shift to shift. • A lack of documentation in the Integrated Progress Notes and other records made it difficult to determine when changes in health status initially occurred. • A lack of complete and appropriate nursing assessments in individuals' responses 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	

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		frequency of the monitoring. • Physicians were not consistently notified in a timely manner of individuals' changes in status. • The method temperatures were taken was rarely documented. • Lack of documentation that there was communication with the Physical and Nutritional Management Team (PNMT) regarding changes in status for individuals at risk of aspiration/choking, skin breakdown, having frequent falls, or other related Physical and Nutritional Management Plan (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. • A 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 (ACPs) for acute changes in status. • Annual and Quarterly Comprehensive Nursing Assessment were not revised to 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 ACPs were initiated. • Lack of adherence to nursing 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. The late entries were documented correctly. The nurses frequently explained the reasons for the late entries were due to the CWS system being down. Examples of individuals with acute change in status that were not adequately assessed, documented, and followed through to resolution: • Individual # 80 had an episode of projectile vomiting in the dining room, which was reported by the direct care professionals at 12:15 p.m. on 2/21/11. The nurse attempted to take vital signs but he only allowed his temperature to be taken, which was 97.3 degrees. Other lung and abdominal assessments were not completed and followed upon according to the Vomiting Protocol. Nor was the Vomiting Protocol	

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		initiated and followed for 48 hours. The physician ordered Individual #80 sent to the emergency room for diagnosis and treatment, including a KUB and chest x-ray. He was diagnosed with severe constipation and was treated with an enema, an intravenous bolus of normal saline, and sent home. Upon return home, the nurse took vital signs, including oxygen saturation (O2Sats), all of which were within normal limits. There was no further documentation in the nursing progress notes regarding vomiting or constipation. The nursing staff failed to follow the Vomiting Protocol that stated, "Assess and document at least every shift for 48 hours after symptom free: Full VS (vital signs), SPO2 (oxygen saturation), report a decrease in SPO2 of < (less) 95% (or below what is designated for that person); Intake and Output; Lung Sounds; Pain assessment if indicated; LOC (level of conscious); Abdominal Assessment; and Presence or absence of nausea. Describe and measurement of vomitus, including hemoccult results if indicated." • Individual #134: Individual #134 was rated at high risk for cardiac disease with diagnoses of hypertension and hyperlipidemia; and high risk for weight with a diagnosis of morbid obesity. He was followed by a cardiologist. On 12/20/12 at 8:04 a.m., the vocational education staff reported Individual #134 was not feeling well and stated, "He was feeling faint and his heart was hard." When taken to the nurse he complained of his left arm feeling weird. He said he thought he slept on his arm. The nurse completed an assessment that included: a mental status exam where he was reported to be alert, orientated to person and place, no pallor of skin, and respirations were even and unlabored. Vital signs were reported as blood pressure 120/68, pulse 102, and O2Sats 97%. Lungs were assessed as clear, a pulse was present bilaterally in arms, and he was able to move arms without difficulty. His gait was steady. The nurse notified the physician of the referral. The physician provided no new orders. The nurse stated she would continue to monitor. There was no further documentation in the Integrated Progress Notes that the nurse continued to monitor Individual #134's cardiac complaint, nor was there documentation in the Physician's Progress Notes that the physician followed-up. Considering Individual #134's cardiac risk factors and the presenting symptoms, the nurse and physician should have continued to assess his cardiac status until there was assurance that he was not experiencing cardiac problems. • Individual #4: The physician diagnosed Individual #4 with an Upper Respiratory Infection/Sinusitis on 2/10/12 and treated with antibiotic therapy. The nurses' Integrated Progress Notes did not: document an assessment of upper respiratory symptoms, document notification of the physician who ordered antibiotic therapy, follow the Antibiotic Therapy Protocol for upper respiratory infections, establish an ACP, and follow the infection to resolution. • Individual #47: On 1/6/12, sometime before 7:30 a.m., the Physician's Progress Notes documented that the nurse reported that Individual #47 vomited while	

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		receiving his enteral feeding. The physician ordered a chest x-ray at 7:30 a.m. The chest x-ray revealed a slight infiltrate in the right lower lobe. The physician ordered Clindamycin 300 mg twice a day for 10 days in anticipation that Individual #47 may have had aspiration pneumonia developing. There were no nursing progress notes on the early morning of 1/6/12 to indicate that Individual #47 had vomited, the physician was notified, or that the nurse had initiated the Vomiting Protocol. The nursing progress notes documented that the first dose of Clindamycin was given at 6:05 p.m. Neither the Antibiotic Therapy Protocol nor the Respiratory Distress/Aspiration Protocols were initiated and followed through to resolution. An Acute Care Plan for Pneumonia was developed, implemented, and the direct support professionals trained with special instructions for the Me Book. However, the baseline data and goals were not clinically appropriate and the plan was not individualized and was inadequate to provide the necessary care according to the Respiratory Distress/Aspiration Protocol. There was no documentation in the nursing Integrated Progress Notes that indicated that the ACP for Pneumonia was initiated and the direct support staff trained. These findings represented poor quality nursing care practices. • Individual #134: On 2/9/12 at 11:00 a.m., the nurse documented in the Integrated Progress Notes that she conducted a Suicidal Risk Assessment. After hearing Individual #134 talking to the QDDP stating, "I'm tired of living. I don't know if my heart will hold for 50 years. I'm prepared to go to heaven." The completed Suicidal Risk Form was given to the Psychologist Assistant. The Psychologist was notified via e-mail; the Executive Officer on Call (EOC) and QDDP were notified via phone. The nurse stated she would follow-up closely PRN. There was no further follow-up on the suicidal ideations documented in the Integrated Progress Notes, printed from CWS, by the nurse or the other disciplines notified. When individuals express suicidal ideations it is essential that they be followed upon until the individual's mental status is evaluated and appropriate psychological counseling and/or other psychiatric treatment provided. <u>Hospital Liaison Nurse Activities</u> At the time of the review the Hospital Liaison Nurse was on an extended leave of absence. The Department of Aging and Disability Services (DADS), Nursing Protocol: Hospitalizations, Transfers and Discharges, Dated: 6/2011, had not been adopted and implemented. The Nursing Department had adopted the Hospital Transfer and the Post Hospital Assessment/Evaluation Forms. They were not in use awaiting a record number. It is essential that the Nursing Department adopt and implement the Nursing Protocol: Hospitalizations, Transfers and Discharges to ensure that the nursing staff are adequately trained to meet all the relevant requirements for managing individuals who	

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		require hospitalization. An example of not following the above policies is the following: • Individual #29: On 12/29/11 at 5:20 a.m., the nurse documented in the Integrated Progress Notes that Individual #29 was found laying in bed covered with coffee ground emesis, as were the bedding and the floor. The nurse described the emesis as projectile vomiting. Vital signs were assessed, lung and bowel sounds were not assessed. The physician was notified who ordered Individual #29 to be sent to the emergency room. The documentation stated that Individual #29 left at 6:00 a.m. via staff. The method of transport was not clear, but it appeared he was transported in the Facility van. Based on the Individual #29's assessment, he was experiencing a medical emergency and should not have been transferred in a Facility van that was not equipped to handle a life threatening emergency situation in route to the hospital. This was discussed with the CNE who provided a copy of RGSC Standard Operating Procedure NR200-30 Nursing Assessment in Acute Situation Policy, Date: 12/1998. This policy did not contain a review/revision date. The procedure for choosing transportation methods stated, "911 or emergency medical services (EMS) will be called for any life-threatening emergency (illness/injury)." The policy did not clearly state who made the decision for method of transport. This was discussed with the CNE who said the nurses usually make the decision. The Nursing Department should review the Nursing Assessment in Acute Situation Policy for clarification regarding method of transporting individuals who are experiencing medical emergencies, and the nursing staff trained to ensure they know when to call 911 or EMS for transport. <u>Infection Control Activities</u> Since the last review the ICP had resigned in November, 2011 and was replaced by the Quality Assurance Nurse in December. The current ICP had begun to follow-up on outstanding infection control issues in addition to assuming the role and responsibilities for the Infection Control Program. The following Infection Control activities were identified during the review: • The quarterly Infectious and Communicable Disease Report had continued. There were currently no reported diagnoses of MRSA, Hepatitis A, B, C, Positive PPDs or Converters, H1N1, C-Diff, HIV, and/or other STDs. • The previous ICP had completed 100% review for the Comprehensive Preventative Health Database, which included immunizations. Corrective actions plans were implemented, analyzed, and trended showing improved compliance over time from 75% to 98.9%. o Individuals current with immunizations were reported as 97%; however, note that Provision L1 reports that appropriate documentation was not consistently available to support immunization for MMR and pertussis.	

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		o Of the individuals who met the criteria for PPD skin testing, 100% of the skin tests were completed. There were no individuals whose skin tests had converted. • The Infection Control Monitoring Tool had been revised and implemented. Four Monitoring tools were completed monthly per the nursing monitoring schedule. • The ICP continued to update the Comprehensive Preventative Health Database by performing a complete verification chart review in conjunction to the revised Infection Control Monitoring Tools and implemented corrective action plans for improvement for identified deficiencies. Corrective action plans were submitted via memo to the respective disciplines for implementation with completion deadlines based on chart reviews. The database appeared effective to track information and identify deficiencies over time. The program indicators completed included: o Determination and assessment of immunization status for identified individuals' monthly and reported quarterly. o Determination of tuberculosis of individuals monthly and reported quarterly. o Trended and analyzed all health acquired infections of individuals monthly and reported quarterly. o Environmental Surveillances completed monthly and reported quarterly. • Since the last review the ICP had begun conducting real time investigations based on review of individuals' recently prescribed antibiotic therapy. The ICP provided the following examples of the real time infection investigations completed: o Presumed conjunctivitis in El Paisano: Investigation completed September, 2011: Individual #118 was diagnosed with "red eye" on 8/13/11 while rooming with Individual #139 who was diagnosed with "pink eye" on 9/10/11. Upon investigation a plan of correction was implemented: Hand hygiene training and reminders were provided to home staff. The affected individuals were separated from individuals who were not infected. Their rooms were disinfected three to four times a day until the infections cleared. The staff continued to monitor other individuals in the home for signs and symptoms of conjunctivitis. All this indicated good practice. The use of ultraviolet lights was recommended in the infection-prone rooms. However, there was no documentation that the ultraviolet lights were used. Current literature has reported that the use of xenon ultraviolet light had the potential to significantly reduce infection-causing bacteria and pathogens, particularly vancomycin-resistant Enterococci (VRE).. Although the use of ultraviolet light to reduce infection in individuals' room does not appear to be common practice in long-term care facilities, it may be worth exploring. o Presumed tuberculosis exposure in La Paloma: Investigation completed January, 2012: Individual #46 was given a PPD on 1/2/12 for complaints of night sweats and abnormal chest x-ray. He was sent to the hospital due to slight induration of	

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		the PPD site less than 24 hours post administration. The pulmonologist encouraged the individual to wear a mask until the tuberculosis was ruled out. A chart review revealed that previous PPD's were negative for the past two years. Individual #46 was not cooperative with wearing the mask at all times and was admitted to Valley Baptist Medical Center. Appropriate tests were negative for acid-fact-bacilli (tuberculosis) and individual #49 was discharged from the hospital on 1/9/12. A plan of correction was implemented. The pulmonologist was available to assist with chest x-ray evaluation for tuberculosis. The Facility's medical staff took appropriate action to diagnose or rule out Individual #46's tuberculosis status. o Presumed gastroenteritis in La Paloma: Investigation completed January, 2012. Several individuals were reported to have vomiting and/or diarrhea. Upon investigation and review of individuals reported, gastroenteritis was not found. The vomiting and/or diarrhea were related to other illness or procedures completed. o Presumed urinary tract infections in male individuals: Investigation completed February, 2012 Of the 46 male individuals living at RGSC, seven were diagnosed with a urinary tract infection (15%). Of the seven individuals, four resided at El Paisano (Individuals #33, #40, #127, and #77), and three individuals resided in La Paloma (Individuals #150, #80, and #134). Of the seven individuals, three met the Center for Disease Control (CDC) guidelines for urinary tract infection because they had diagnosed symptoms leading to collection of urine for urine analysis. The other four urinary tract infections were found on routine urine analysis without symptoms. None of the individuals reviewed experienced more than two urinary tract infections in the year reviewed. A plan of correction was implemented, and relevant staff were trained on the Urinary Tract Infections Policy. Although the above documentation indicated that real-time investigations were conducted on infections, at the time of the review, 11 individuals had active infections. Samples of five records for active infections were reviewed, which included Individuals #4, (urinary tract infection) #149 (otitis externa), #54 (urinary tract infection), #108 (urinary tract infection), and 19 (upper respiratory infection). The findings included: • None of five (0%) active infections had documentation in the Integrated Progress Note's indicated the ICP had been notified of the infections or had completed real-time investigations. Three urinary tract infections were for females, e.g., #54, #108, and #4, who resided in La Paloma. Three of 15 females with urinary tract infections represented 20% of the females residing in La Paloma. Considering that 20% of the female residents had concurrent urinary tract infections in the same home, the ICP should conduct real-time investigations to determine the possible origin of the infections and to take	

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		preventative measures if indicated. Conducting real-time investigations was discussed with the ICP. When the ICP was asked how she identified infections at the time they were diagnosed, she stated she found them on the 24-Hour Nursing Report. The nursing staff were not completing Infection Reports nor submitting information to the ICP when individuals were diagnosed with infections. This was discussed with the CNE who said she would send a directive to the nursing staff to complete Infection Reports and submit them to the ICP for follow-up investigations. The ICP stated she did not have a formal process for checking the reliability for reporting infections. • None of five (0%) individuals with infections had documentation in their Integrated Progress Notes' that the nursing staff carried out appropriate protocols, e.g., Antibiotic Therapy, Urinary Tract Infections, and Upper Respiratory Distress/Aspiration Protocols. The failure of the nursing staff to follow the required protocols was discussed with the CNE, Nurse Manager, Nurse Case Managers, and Nurse Educator. The CNE and Nurse Educator discussed the possibility of placing the nine recently developed protocols templates in CWS to assist and ensure the nursing staff followed the protocols through to resolution. In addition, the Nurse Educator agreed to monitor all protocols to ensure the nurses' competencies and that they are followed as specified through to resolution. • None of five (0%) individuals had ACPs developed and implemented for their infections. The Monitoring Team discussed with the ICP the need for collaboration with the nursing staff on the development of ACPs and HMPs for acute infections and chronic infections to ensure they are clinically appropriate and include preventative interventions. • Individual #149, who had a history of chronic ear infections, was diagnosed on 2/17/12 with otitis external and was prescribed antibiotic therapy. The physician's Integrated Progress Notes stated that her right ear canal was red and had some possible purulent drainage. The drainage from the ear canal was not cultured. It is important to culture such drainage since the ears are prone to harbor MRSA, fungus, and other organisms. It is essential that the most effective antibiotics are prescribed. A review of the CTD Due/Delinquent List of Infection Control Training, 1/30/12, indicated that all staff were current in Infection Control Training. A review of the monthly Safety/Risk Management/Infection Control Committee minutes, 8/2011 through 1/2012, revealed that infections were reported monthly by type,	

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		number, and rate, including rate of nosocomial infections, except for 11/2011 (prior to the replacement of the ICP). The monthly rate of non-reportable infectious/communicable diseases included: • July – 17 Infections = 24% Rate; 6% Nosocomial Rate • August – 16 Infections = 22.50% Rate; 6% Nosocomial Rate • September – 12 Infections = 16% Rate; 0% Nosocomial Rate • October – 15 Infections = 21% Rate; 0% Nosocomial Rate • December – 24 Infections = 34% Rate; 7% Rate Healthcare Associated Infections (Infections caused by a wide variety of common and unusual bacteria, fungi, and viruses during the course of receiving medical care.) Although there was documentation reviewed validating that the ICP conducted real time infection investigations with plans of correction; they were not discussed in the Safety/Risk Management/Infection Control Committee minutes. Neither did the minutes contain any discussion and/or plans of corrective action to reduce or eliminate the rate of infections for the identified infections. In addition to reviewing the above minutes, the monthly/quarterly Infection Reports were reviewed and no reportable infectious/communicable diseases were found during the past six months. The Infection Control Program continued to use the Dallas County Health and Human Services County-wide 2009 Antibiogram and the Valley Baptist Medical Center's Antibiotic Susceptibility of Common Organisms Report, September 2008 through August 2009. This outdated information was discussed with Dr. Dill, who stated they were the most current available but agreed to research more current information to use in prescribing antibiotic therapy. There was no documentation supplied that indicated that the ICP reviewed the Antibiogram and Antibiotic Susceptibility of Common Organisms Report with the Pharmacy and Therapeutics Committee to ensure the susceptibility/effectiveness of the antibiotic therapy prescribed, as required by the Settlement Agreement. The ICP should review the Antibiogram and Antibiotic Susceptibility of Common Organisms with the Pharmacy and Therapeutics Committee to ensure the susceptibility/effectiveness of the antibiotic therapy prescribed, as required by the Settlement Agreement. Although there had been some improvements made, this sub-section of the provision was not found in compliance; the Facility should maintain the positive practices identified in the report and make improvements on the following practices: The Nursing Department should: • Ensure that the nursing staff complete the Infection Report when infections are diagnosed and submit the report promptly to the ICP for real-time follow-up investigations.	

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		• Ensure that the ICP implements a formal process for checking the reliability of infection reports. • Ensure that the Nurse Educator monitors all protocols for nurses' competencies and that they are followed as specified. • Ensure that the ICP collaborates with the nursing staff on the development and implementation of ACPs and HMPs for acute and chronic infections to ensure they are clinically appropriate and include preventative interventions. • Ensure the ICP collaborates with physicians regarding performing culture and sensitivity studies for relevant infections to ensure the most effective antibiotics are prescribed. • Safety/Risk Management/Infection Control Committee should explore causative/contributing factors leading to the reported infection rates and make recommendations for corrective action to reduce or eliminate the reported infections. • The ICP should make every effort to obtain a current Antibiogram and Antibiotic Susceptibility of Common Organisms Report common to the Rio Grande area to ensure the most effective antibiotic therapies are prescribed to treat infections. <u>Skin Integrity Activities</u> A review of the tracking system for skin breakdown/decubitus found there were no current incidents of skin breakdown or decubitus, nor had any been reported in the past six months. The Nursing Department did not have a dedicated Skin Integrity Nurse. A review of the Infection Reports found numerous incidences of cellulitis infections. Cellulitis is a skin integrity issue caused by bacteria that should be reported as such and followed-up by the ICP. On 12/10/11 at 11:00 a.m., while the PNM Nurse was making routine head of bed elevations checks, she found Individual #79 to have redness on both heels and assessed the heels to have beginning stage of pressure sores. The pressure sores were more prominent on the right heel. The plan was to place a pillow under the ankles to relieve pressure and to order an air mattress. The staff nurse notified the physician of the redness to Individual #79's heels and gave an order to keep pressure off heels and for the nurses to monitor for 24 hours. There was no documentation in the Integrated Progress Notes that Individual #79's heels were monitored for 24 hours. It is essential when potential skin breakdown is recognized that it is aggressively assessed. Unfortunately, there was no documentation that Individual #79's heels were monitored until two days later. On 12/12/11 at 3:15 p.m., nursing assessment reported both heels were normal pink color. She documented that Individual #79 was at risk for impaired skin integrity due to a history of decubitus. The physician had ordered the use of waffle boots bilaterally to prevent skin breakdown. There were no further progress notes regarding	

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		the status of Individual #79's heels. It was positive to find: that the PNM Nurse assessed the individual's heels, found pressure to the heels, and recommended interventions to decrease pressure on the heels; and that the unit nurse notified the physician. It was of concern that there was no documentation the nursing staff monitored Individual #79's heels for 24 hours as ordered. The nursing staff should have monitored her heels every shift for 24 hours or longer to ensure the pressure was relieved. The delay of two days to assess the heels was not acceptable nursing practice. The delay could have resulted in not promptly recognizing increased pressure with actual skin breakdown of the heels. Performing assessments of the heels was even more important due to her reported history of decubitus. There was no further documentation that the waffle boots were secured, applied, or if the boots were effective in reducing pressure to the heels. <u>Medical Emergency Response Activities</u> Since the last review the Facility had continued to make improvements in their Medical Emergency Response System. Improvements included: • A review of the required emergency equipment against the Medical Emergency Response, Standard Operating Procedure, ICF-DD 100 18, , found that all the required emergency equipment was present in the designated areas. This included storage of an oxygen tank in the Vocational Services area, which was previously described as a problem due to lack of a secured area for storage. The nursing staff brings the medication box to the scene for the units. • The location of emergency equipment was clearly posted in the designated areas. • In December, 2011 the revised Emergency Response Policy forms had been adopted and implemented. The revised forms included: Medical Emergency Drill Checklist, Emergency Oxygen Tank and Suction Machine Checklist, AED and Emergency Bag Check Off Sheet, and Emergency Equipment Walkthrough Checklist. • There was documentation that at least 71% of the nursing staff had received competency-based training on the emergency equipment. There were no projected dates for training the remaining 29%. • The Facility reported that the nursing staff had maintained the Medical Emergency Checklists according to policy, as described in the table below:	

Month - 2011	La Paloma	El Paisano	Vocational Services
July	100%	0%	6%
August	100%	0%	100%
September	100%	0%	100%
October	97%	97%	100%
November	100%	100%	100%
December	100%	93%	100%

The Monitoring Team's review of the Medical Emergency Checklists, 1/2012 and

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		2/2012, found the AED and Emergency Bag Check Off Sheets were not consistently checked daily in El Paisano and La Paloma. All of the other required emergency equipment checklists were checked daily, except for the Vocational Services area where the equipment was not checked on weekends and holidays because this area was not in use. • Maintained a Mock Medical Emergency Drill Schedule and validated that drills were completed as scheduled. The outcomes of drills were beginning to be tracked, analyzed, graphed, and reported to the Quality Assurance Department. Trends indicated that over 90% of the drills were successful. • A review of the 35 completed Mock Emergency Drill Checklists indicated the nursing staff consistently participated in the drills. The physicians were beginning to participate. It was impressive to find in the drills conducted in El Paisano where the physician participated, that he had instructed the nursing staff in proper use of the Ambu-bag. It was positive to find that all emergency equipment was checked during the drills for proper working order and that the psi of the oxygen tanks was also checked to ensure they contained an adequate supply of oxygen. • A review of the completed drill sheets, 9/2011 through 12/2011, validated that the Facility continued to provide "on the spot" retraining when indicated; and staff that were not successful were sent to CTD for refresher training. • A review of the CTD Due/Delinquent List for CPR Training, 1/31/12, indicated all staff were current in CPR Training. • The CNE or designee was appointed in October, 2011, as a standing member on the Safety/Risk Management/Infection Control Committee. A review of the Safety/Risk Management/Infection Control Committee Meeting minutes, 8/2011 through 1/2012, found that the results of the Mock Medical Emergency Drills were reviewed, discussed, and when indicated plans of correction were developed, implemented, and followed through to resolution. Example: Communication/announcement of Mock Medical Emergency Drill, particularly in the Vocational Services area, had been an ongoing problem discussed in the committee meetings with numerous strategies attempted to resolve the problem. A decision was made to provide the Nurse Managers with a dedicated cell phone. The Nurse Case Managers rotate carrying the cell phone. A copy of a signed Training Roster was provided to validate that the relevant staff were trained on the cell phone number. In addition to reviewing the result of the Mock Medical Emergency Drills at the Safety/Risk Management/Infection Control Committee, the results of the drills were present at the Incident Management Committee meeting the next day after the drills were conducted. An impromptu Mock Medical Emergency Drill was called on the Vocational Services grounds on 3/1/12. Staff responded to "man down" within one second and began	

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		resuscitation efforts. The Vocational Staff, including the housekeeping staff, immediately responded to the scene with all of the necessary emergency equipment. It was readily apparent they had been participating in the drills and knew the location of the emergency equipment and their role and responsibilities. Other Vocational Services staff made the phone calls to the nursing staff and to simulate calling 911, other staff took the golf cart to get the nursing staff, and another staff went to the entrance of Facility to simulate flagging the emergency services to the scene. The nurse's cell phone worked and the nursing staff arrived at the scene with the emergency box within four minutes. The drill was completed successfully with only two deficiencies. The first responder performing resuscitation gave two breaths before starting chest compressions. The nurse did not follow the commands of the AED machine. The two staff were provided with retraining "on the spot". After the drill the a debriefing was completed by the Monitoring Team with the Interim Vocational Services Manager, Risk Manager Supervisor, CNE, Unit Nurse Manager, Nurse Educator, and the Quality Assurance Nurse to critique the drill performance. Issues discussed regarding the Facility's Emergency Response System included: • The Risk Manager Supervisor suggested videotaping the Mock Medical Emergency Drills to use as a training aid, and the group agreed. • The issue of using a portable suction machine in the Vocational Services area was discussed. The group told the Monitoring Team that they were prohibited from using the portable suction machine by the Life Safety Committee and DADS because portable suction machines' suction was not strong enough to supply adequate suction; and only the use of an electrical suction machine was acceptable. This issue was discussed earlier with the Nursing Leadership. They stated they had been informed by DADS to include extension cords in their emergency equipment. The logistic of using an extension cords in the Vocational Services area and on grounds was impractical since they would need at least 150 feet of cord to reach from one building to the other, much more if it was needed out on the campus grounds. The Nurse Educator was able to demonstrate that the portable suction machine had the ability suction a cup of honey thickened liquid and/or apple sauce via yankuer at 100 to 120 mmhg of pressure, as required in the RGSC Suction Machine Guidelines. This poses the question, is it wiser to use the portable suction machine in an emergency as opposed to delaying the resuscitation efforts while many feet of an electrical cord is run to the machine or to use the portable suction machine that has demonstrated adequate suction to save a life? It is a given that the suction machine batteries must always be operational. The Risk Manager Supervisor stated that the battery charge should be no problem if the batteries were changed monthly. Following the compliance visit, the Monitoring Team was notified that the information was not entirely accurate. Portable suction machines may be used where needed. However, regular suction machines are to be used in areas where	

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		there is electrical plug-in access; extension cords should be available in those areas. It is essential that Facility staff are fully aware of the expectations for use of regular versus portable machines, and that they use the most readily available machine. This issue should be further explored with the Life Safety Committee and DADS to ensure that suction machines are accessible in all areas on the campus when needed for emergency situations, that extension cords are available where needed, and that staff know where machines are available. • The issue of procuring a golf cart specifically for the nursing staff to use to respond to Mock Medical Emergency Drills and/or actual codes in the Vocational Services area because of the distance away from the living units was discussed. However, the request for the golf cart was denied. • An interview with the Interim Vocational Services Manager indicated that the policy requirement for the Campus Coordinators to complete Emergency Equipment Walkthrough Checklist had not been implemented, nor had they been trained in the revised Emergency Response Policy or the Emergency Drill Instructor Training for Conducting Emergency Drill. Presently, only the Interim Vocational Services Manager was trained to conduct the drills. Consequently, before the end of the review, the Campus Coordinators were trained on the revised Emergency Response Policy, including their responsibilities for completing the monthly Emergency Equipment Walkthrough Checklists and the Emergency Drill Instructor Training for Conducting Emergency Drill. The Interim Vocational Services Manager stated the Campus Coordinators would begin conducting the monthly Emergency Equipment Walkthrough Checklists, as well as assisting with conducting Mock Medical Emergency Drills. • It was identified that there was no written procedure for executing the use of the cell phone for Mock Medical Emergency Drills and/or actual codes. The Interim Vocational Manager drafted a procedure before the end of the review that will be finalized and put in place. • There was documentation that the nursing staff had been trained on the Emergency Equipment and Checklists, but there was no documentation that the nursing staff had been trained on the revised Emergency Response Policy. The Nurse Educator was made aware of the lack of nurses' training on the revised Emergency Response Procedure and agrees to ensure the training was provided. The Monitoring Team will follow-up on this issue at the next review. Although there had been some improvements made, this sub-section of the provision was not found in compliance; the Facility should maintain the positive practices identified in the report and make improvements on the following practices: • The Facility should continue to explore with the Life Safety Committee and DADS the use of portable suction machine in areas on campus where it is not feasible to use an	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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electric suction machine, e.g., the Vocational Services area and campus grounds.
• The Interim Vocational Services Manager should ensure that the Campus Coordinators complete monthly Emergency Equipment Walkthrough Checklists.
• The Nursing Department and Interim Vocational Services Manager should ensure that all required emergency equipment are checked daily for proper working order, oxygen tanks checked for an adequate supply of pressure, and missing and/or expired equipment replaced.
• The Nurse Educator should ensure that all nurses are trained on the revised Emergency Response Policy and emergency equipment.

<u>Quality Enhancement Efforts</u>
Since the last review the Nursing Department had revised the procedure and number of Nursing Care Monitoring Tools reviewed. The Nurse Case Managers (NCM) completed each other's records according to the assigned schedule. The number and type of tools monitored monthly included:
<table>
<tr><th>Routine Monitoring Tools</th><th>Sampled Monitoring Tools</th></tr>
<tr><td>Nursing Care: Documentation (4-1 per NCM)</td><td>Seizure Management (1 per month by NCM)</td></tr>
<tr><td>Annual Nursing Assessments (4-1 per NCM)</td><td>Pain Management (1 per month by NCM)</td></tr>
<tr><td>Prevention (4-1 per NCM)</td><td>Management of Chronic Respiratory Distress (1 per month by NCM, if applicable)</td></tr>
<tr><td>Skin Integrity (4-1 per NCM)</td><td>Urgent Care/ Emergency Room Visits/ Hospitalization (1 per month by NCM, if applicable)</td></tr>
<tr><td>Nursing Care Plans (4-1 per NCM)</td><td>Acute Illness and Injury (1 per month by NCM, if applicable)</td></tr>
<tr><td>Infection Control (1 by Infection Control Nurse</td><td>None</td></tr>
<tr><td>Medication Administration Observation (UNM per quarterly schedule)</td><td>None</td></tr>
</table>

The Quality Assurance Department had continued to revise and refine the monitoring process. The Facility had adopted a methodology for review of data referred to as CATW2. CATW2 refers to <u>C</u>heck, <u>A</u>sk, <u>T</u>hink, <u>W</u>hy, and <u>W</u>hat. This methodology was developed by the Facility to encourage those reviewing data reports to engage in critical thinking. The results of the Nursing Care Monitoring Tools were reported quarterly to the Settlement Agreement Performance Improvement Committee (SA-PIC). CATW2 were required for monitoring tools falling below 90%. However, the Nursing Care
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		Monitoring Tools results for the past six months presented to the SA-PIC and summaries of the quarterly data and outcome for all the 12 tools were not made available for Monitoring Team review. The completed monitoring tools, 9/2011 through 12/2011, provided for Monitoring Team review did not show evidence they were analyzed and trended by the Facility. Therefore, the status of compliance for the Nursing Care Monitoring Tools could not be determined. The information provided in the Section M Presentation Book included the following information regarding the Nursing Department's self-assessment audits for the past six months: • Insulin Administration: The audit included documentation of the glucometer results, insulin administration, and physician order's for insulin. RGSC only had two residents on insulin. There was evidence to show that in the last five months there had been 100% compliance, except for 8/2011 where the data showed 67% compliance. The insulin administration was not documented on the paper Medication Administration Resident of the individual. The MediMar system indicated the documentation of insulin administration. The Nursing Department acknowledged there were opportunities for improvement which included that the UNM would continue with daily rounds, utilization of the insulin administration checklist, and to implement positive performance counseling. • Nursing Assessment Completion/Authentication: The audits included the requirement for annual nursing assessments to be completed within 10 days prior to annual ISP review and quarterly nursing assessments to be completed within the month due for quarterly reviews. Data reflected lack of compliance in the earlier audits, e.g., 82% for 8/2011 and 71% for 9/2011. Currently compliance was reported at 95 to 100%. The lack of compliance was attributed to the transition of the NCMs' who also worked as staff nurses providing direct care which limited their time to meet the expectation for completing the nursing assessments as required. In addition, there was a significant reduction in workforce due to two RN frozen positions. As of October, 2011, NCMs shifts were changed to work Monday through Friday from 8:00 a.m. to 5:00 p.m. The significant increase in recent compliance was attributable to the NCMs shift change, hiring two RNs, and the return of a RN from leave. • The 24-Hour Chart Checks Review to ensure that Physician Order's were transcribed and carried out: The audits included checking medication and treatment orders that were transcribed in CWS. The audit also included the 24-hour chart check completed by the night shift nurse to ensure they were dated and stamped with the nurse's initial for each physician order. The data reflected 95.4% compliance in the transcription of medication errors for the six individuals whose records were audited. There were opportunities for improvement by re-training nurses at the monthly nursing meetings to ensure that all physician orders were transcribed correctly.	

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		• Monthly Consultation Audits: This audit was initiated in January, 2012. The audits included reviews of dates the Facility physicians ordered the physician consultations, dates the physician consultations were scheduled, dates physician consultations were received, and dates the Facility physicians reviewed the consulting physicians' findings (dictated or written reports). Because the NCM and/or Hospital Liaison Clerk found that appointments were often rescheduled or missed, this information was added to the Medical and Dental Tracking Database to ensure appointments were reschedule to avoid missed appointments. The Nursing Department should ensure that all Nursing Care Monitoring Tools are completed according to schedule, sent to the Quality Assurance Department to enter into the Quality Assurance Database, analyzed, and trended for compliance. For the tools falling below 90%, a systemic CATW2' should be developed, implemented, and followed through to resolution. Progress toward compliance with all Nursing Monitoring Tools will be followed-up at the next review.	
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.	The Facility's Section M Self-Assessment stated they were not in compliance with this provision and the Monitoring Team concurs. Through review of Section M Self-Assessment, Section M Presentation Book, staff interviews and review of documents, it was evident the Nursing Department had made minimal improvement toward achieving compliance with the requirements contained in this provision. Admission, Discharge, Annual, and Quarterly Comprehensive Nursing Assessment were reviewed for Individuals #33, #47, #80, #134, #108, #79, #98, #29, #127, #5, and #13 Of the 11 individuals' Annual and Quarterly Comprehensive Nursing Assessments, 39 were reviewed. The findings included the following: • Thirty-nine of 39 (100%) Annual and Quarterly Comprehensive Nursing Assessments were completed by the Nurse Case Managers. • Thirty-nine of 39 (100%) Annual and Quarterly Comprehensive Nursing Assessments had BRADEN skin integrity assessments completed. • A review of the 39 Annual and Quarterly Comprehensive Nursing Assessment found the following trends: o Current active medical diagnoses were consistently included. o Sections I through IX of the assessments found the following problematic issues upon review of the Annual and Quarterly Comprehensive Nursing Assessment: ▪ Consults were not consistently summarized. ▪ The effectiveness of medications were not consistently documented and summarized. ▪ The individuals with identified weight issues were not consistently	Noncompliance

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		summarized to reflect the status of progress or lack of progress regarding weight management plans. ▪ Tertiary care was not consistently summarized to reflect the reason for tertiary care and outcome of the tertiary care. ▪ Immunization status for all required vaccines, particularly Measles Mumps, and Rubella (MMR) were not consistently documented. The immunization assessment section did not contain a block regarding Polio immunizations. None of the individuals' Polio vaccination status were included. ▪ Annual Tuberculosis Skin Tests and/or screenings were not current for all individuals. There was no explanation in the immunization summaries for the delinquency. ▪ Annual male breast exams and monthly female breast exams were not consistently documented. ▪ Physical Assessments of systems related to high and medium risk ratings were not consistently summarized to indicate past history and current status. o Sections X Nursing Problems/Diagnoses: Of the 11 individuals' all (100%) were identified as having one to 15 high and medium risk levels identified. In comparing the most recent high and medium risks identified through the At Risk Assessment Screenings to Section X, Nursing Problems/Diagnoses, the high and medium risk levels were not consistently included on the problem lists. This may be due to changes in individuals' risk levels after the quarterly/annual nursing assessments were completed. When individuals' risk levels change to high and medium risks, the Nurse Case Managers should complete addendums to nursing assessments to reflect changes in risk levels that require the addition of new nursing problems/diagnoses to the lists. For every nursing problem/diagnosis listed there should be a HMP, conversely for every HMP there should be a nursing problem/diagnosis. Refer to Section M.3 regarding issues related to HMPs. Despite the training and monitoring the Nursing Department had put forth in order to improve the quality of the Section XI Nursing Summary's, since the last review no significant difference was noted in the analyses and summaries of clinical data. The quality of the nursing summaries varied from unit to unit and Nurse Case Manager to Nurse Case Manager. A review of the Section XI Nursing Summaries found the following: • Since the last review in order to improve the analysis of clinical data, the Nursing Department had revised the format for Section XI, Nursing Summary into a variety of subsections which included: o Review of Health Status from previous quarter/annual, to include any surgeries o Health Risk Review	

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		o Nursing problems/Diagnoses identified and read for the diagnoses o Health Management Plans and Progress. o Community Integration • A review of the revised format used for documenting the quarterly/annual nursing summaries found that the segregation of the clinical data did not improve the quality of the summaries. The items contained in the summaries continued to contain raw clinical data without analyses to identify individuals' health status in relation to their problems. With the additional categories in the format, the clinical data were more fragmented, making it even more difficult to discern the individuals' health status in relation to each of their problems. • It was further apparent that all levels of nursing management lacked a clear understanding as to how to analyze, summarize and present clinical data related to individuals' health problems to determine whether or not there was progress related to their health problems. At the time of the review neither the Nurse Educator or the Nurse Case Managers, and other RNs had received the mandatory Physical Assessment and Documentation Class. This class should improve the RNs' physical assessment skills and knowledge and improve the quality of all nursing assessments and documentation. • The summaries did not clearly indicate the effectiveness of the HMPs or the need for revision or that they were revised. • Most summaries were written in capital letters, and had long run-on and fragmented statements, which made the content difficult to read and understand. The State Office had revised the Admission and Discharge to Community or Other Facilities Nursing Assessment format, including a section for special discharge instructions. The Nursing Department had not adopted and implemented the revised forms. The need to adopt, and implement the revised Admission and Discharge to Community or Other Facilities Nursing Assessment was discussed with the Nurse Educator, Nurse Manager, and Nurse Case Managers. The Nurse Case Manager who was working on the discharge plan for three brothers, who were soon to be discharged, immediately revised the Comprehensive Nursing Assessment for Individual #13, to contain a comprehensive discharge plan that included special instructions for training the receiving agency staff. A review of the assessment and plan for special instructions showed promise and a good format for future discharge plans. In order for improvements to be made regarding HMPs and ACPs, as required in this provision of the Settlement Agreement, the Nursing Department should ensure the following: • The Nurse Case Managers complete an addendum to the Quarterly Comprehensive Nursing Assessment when there are changes in individuals' risk ratings or other	

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		significant changes in health status, and revise and/or develop and implement HMPs for changes in status. • The Nurse Managers summarize each nursing problem/diagnosis separately for clarity. • The Nurse Case Managers avoid writing nursing summaries in capital letters with long run-on statements. • Adopt and implement the revised Admission and Discharge to Community or Other Facilities Nursing Assessment format, including a section for special discharge instructions, as well as train the Nurse Case Managers. • Schedule the Nurse Educator for the mandatory Physical Assessment and Documentation Class. Then, train the Nurse Case Managers and other RNs. The Facility and/or State Office should consider providing the Nursing Department with technical assistance from an expert to provide competency-based training to assist the relevant nursing staff with critically analyzing clinical data into clear and concise summaries reflective of individuals' health status.	
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.	The Facility's Section M Self-Assessment stated they were not in compliance with this provision and the Monitoring Team concurs. Through review of Section M Self-Assessment, Section M Presentation Book, staff interviews and review of documents, there was evidence that the Nursing Department showed no significant improvements toward achieving compliance with the requirements contained in this provision. As found in past reviews, a review of 10 individuals' HMPs and ACPs showed they continued to be generic and were copied directly from the Nursing Care Protocols for Developmental Disability Nurses' template. The plans were not individualized to meet individuals' specific needs in relation to their identified risks and/or active medical problems that required nursing interventions. A review of HMPs and ACPs for Individuals #33, #47, #80, #134, #108, #79, #98, #29, #127, and #5 revealed the following: • A total of 49 HMPs were reviewed that indicated: o Twelve of 49 (24%) had adequate baseline data stated for the identified health problems. o Nine of 49 (18%) had adequate goals stated to measure the desired outcome for the identified HMPs. o None of 49 (0%) HMPs were individualized sufficiently to meet the individuals' health care needs. The HMPs continued to be developed from the Nursing Care Protocols for Developmental Disability Nurses' template. As reported in past reviews, these generic plans were not individualized to meet individuals' specific health care needs. Rarely were nursing interventions found that related to	Noncompliance

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		individuals' specific needs. o None of 49 (0%) HMPs were developed in collaboration with other relevant disciplines, with the exception for occasionally referring to other disciplines, e.g., PNMPs and/or PBSPs. o None of 49 (0%) HMPs included proactive/preventative measures to reduce and/or eliminate risk indicators/problems. o None of 49 (0%) specified the frequency the interventions were to be carried out, by whom, and where the interventions were to be documented. o None of the 49 (0%) contained documentation in the Nursing Integrated Notes that the HMP interventions were carried out as described. o Forty-one HMPs were due to be reviewed/revised at the time of Annual and/or Quarterly Comprehensive Nursing Assessments or when health status changed. Thirty-one of 41 (75%) were reviewed at the time of the Annual and/or Quarterly Comprehensive Nursing Assessments. None were revised. o Thirty-nine of 49 (80%) HMPs contained documentation that the direct support professionals were trained and had special instruction sheets developed for the Me Books. o One of 10 (10%) individuals (#134) had HMPs developed and implemented for all high and medium risk ratings. o The remaining nine of 10 (90%) individuals did not have HMPs developed and implemented for all high and medium risk ratings. Examples of individuals' high and medium risk ratings for which HMPs should have been developed and implemented included: ▪ Individual #33: Diabetes. ▪ Individual #47: Gastrointestinal Problems, Constipation, Cardiac Disease, and Polypharmacy. ▪ Individual #80: Aspiration, Respiratory Compromise, Cardiac Disease, Falls, Fractures, and Polypharmacy. ▪ Individual #108: Weight, Circulatory, Gastrointestinal Problems, and Osteoporosis. ▪ Individual #79: Cardiac Disease, Circulatory, Constipation, Osteoporosis, Falls, Fractures, Urinary Tract Infections. ▪ Individual #98: Osteoporosis, Falls, and Polypharmacy. ▪ Individual #29: Choking, Aspiration, Dysphagia, Respiratory Compromise, Cardiac Disease, Circulatory, Gastrointestinal Problems, Osteoporosis, Skin Integrity, Infection, Pain, Fluid Imbalance, Dehydration, and Hypothermia. ▪ Individual #5: Osteoporosis, Falls, Fractures, Skin Integrity, Gastrointestinal Problems, Constipation, Infection, and Pain. o Frequently individuals who had complex medical/health conditions had generic Health Management Plans for Developmental Disabilities. This plan was designed for routine care and is not adequate to meet individuals' high and/or	

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		medium risks or active medical problems needs. The plan addressed routine care and was too general and nonspecific to address complex medical needs. This plan should not be used for high and/or medium risks or active medical problems. Some of the interventions contained in the plan were grossly inappropriate for routine care, e.g., in-service training for direct support staff stated, "Eyelid Care - Scrub the lid margins and lashes on closed eyelids with a cloth. Massage lid margins to stimulated flow of secretions then cleanse with a cotton swab dipped in warm water or diluted shampoo and rinse if shampoo is used." Unless the individual had a specific problem with eyelids and required such cleansing, this is not routine care for washing eyes. This method of cleansing the eyelids should not be included in the direct care professionals' instructions unless it is specifically indicated and prescribed. Copies of all ACPs for the 10 individuals reviewed were requested for offsite review. Only six ACPs were provided for review. Therefore, it could not be determined if no other ACPs were developed or just not copied for review. A review of the individuals' Nursing Integrated Progress Notes, Physicians' Orders, and Progress Notes indicated there were numerous changes in individuals' health status that should have required the development and implementation of ACPs. A review of the available ACPs revealed the same problematic issues as were found in review of the HMPs. Those findings included: • Two of six (33%) had adequate baseline data stated for the identified health problems. • Two of six (33%) had adequate goals stated to measure the desired outcome for the identified ACPs • None of six (0%) ACPs were individualized sufficiently to meet the individuals' health care needs. The ACPs continued to be developed from the Nursing Care Protocols for Developmental Disability Nurses' template. As reported in past reviews, these generic plans were not individualized to meet individuals' specific health care needs. Rarely were nursing interventions found that related to individuals' specific needs. • None of six (0%) ACPs indicated they were developed in collaboration with other relevant disciplines. • None of six (0%) ACPs included proactive/preventative measures to reduce and/or eliminate risk indicators/problems. • None of six (0%) ACPs specified the frequency the interventions were to be carried out, by whom, and where the interventions were to be documented. • None of the six (0%) ACPs contained documentation in the Nursing Integrated Notes that the ACP interventions were carried out as described. • The interventions described in the ACPs were not consistent with the Nursing Department's protocols or physician orders.	

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		In order for improvements to be made regarding HMPs and ACPs, as required in this provision of the Settlement Agreement, the Nursing Department Should ensure the following: • HMPs address all high and/or medium risk indicators and active problems that require nursing interventions. • HMPs are individualized to meet individuals' specific health care needs in relation to their identified risks and/or active medical problems. • HMPs are reviewed and/or revised at the time of the quarterly/annual nursing assessment or when there was a change in health status. • ACPs and HMPs include proactive/preventative measures to reduce and/or eliminate risk indicators/problems. • ACPs and HMPs contain integrated interventions in collaboration with other relevant disciplines, as required in Sections G and F of the Settlement Agreement. • ACPs and HMPs include who would implement the nursing interventions, how often they would be implemented, where they were documented, and how often they would be reviewed and/or revised.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	The Facility's Section M Self-Assessment stated they were not in compliance with this provision and the Monitoring Team concurs. Through review of Section M Self-Assessment, Section M Presentation Book, staff interviews and review of documents, there was evidence that the Nursing Department had continued to make steady progress toward achieving compliance in all of the various requirements contained in this provision. Since the last review a full-time Nurse Educator was hired on 11/16/11. It was impressive to find that in the short time since the Nurse Educator was hired that he had made significant improvements to the nursing education procedures and processes. The improvement noted through interview with the Nurse Educator and review of training documents included: • The Nursing Training Tracking Database had been totally revised to provide comprehensive information regarding training activities and to improve the quality of the training. This included date topics were trained, name of the nurses trained, the nurse's scores attained on the competency-based training for each topic, the overall percentage of the nursing staff trained on each topic, and a projected date for achieving 100% of the training for each topic. • Developed and implemented a Nurse Competency Process. • Began developing and implementing competency-based training curricula for courses taught: o The curricula included measurable/realistic course objectives based on course	Noncompliance

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		content. o Developed competency-based testing for each course taught, including direct observation and/or return demonstrations when applicable. o Developed and implemented a Course and Instructor Evaluation for each course taught in order to further improve the quality and effectiveness of training. o Follow-up evaluation of nurses' competency for each course taught at two, five and 10 weeks intervals. o A CATW2 will be implemented for nurses failing to achieve at least 90% score on courses taken. A review of two curricula developed to date for Blood Glucose Monitoring and Vital Sign Assessments demonstrated that the above improvements had been put into practice. The above improvements made to nursing training appeared promising to improve the quality of nursing care. This issue will be followed-upon at the next review to evaluate the effectiveness of the training. It was positive to find that the Nurse Educator had received continuing education, on January 19 and 20, 2012, for 16.5 contact hours on the 2012 Winter Essentials of Infection Control and Prevention, presented by the Texas Society for Infection Control and Prevention. A review of the nurses' training that occurred from 9/1/11 through 1/27/12 indicated that although numerous topics had been taught, none had achieved 100% completion. Most concerning was the continued lack of training on all core nursing policies and protocols developed and implemented by the State Office. While the various forms associated with such polices/protocols, such as the Medication Variance, Emergency Response, and Hospitalization, Transfers and Discharges, had been adopted and implemented, there was no evidence that the nursing staff had been trained on the actual policies and/or protocols. Therefore, it could not be determined if these policies and protocols had been adopted and implemented beyond the use of the associated forms. The Nursing Department should ensure that all core nursing policies and protocols, and other policies and protocols related to nursing practices, are adopted, implemented, and the nursing staff trained on such, not limited to the associated forms. There was documentation that 100% of the nursing staff had been trained during 1/2012 and 2/2012 on the nine protocol cards for: Antibiotic Therapy, Vomiting, Respiratory Distress/Aspiration, Pre-Treatment and Post-Sedation, Diarrhea, Temperature Elevations, Constipation and Head Injury, and When Contacting the PCP, document that you provided the following. However, a review of the Integrated Progress Notes for five individuals receiving antibiotic therapy for infections, and one who experienced an episode of vomiting and was hospitalized, found that none of the	

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		protocols were carried out as specified on the protocol cards. This was discussed with the Nurse Educator who will follow-up on monitoring/evaluating the nurses' competency on protocols. Refer to Provision M.1, Assessment and Documentation of Individuals with Acute Changes in Status, for details regarding these findings. The part-time Nurse Educator who had completed the mandatory Physical Assessment and Documentation Class in May, 2011, had resigned. None of the NCMs or other RNs had received training on the class. This was discussed with the newly assigned full-time Nurse Educator who stated he had not been scheduled to attend the class. The Nursing Department should ensure that the newly assigned full-time Nurse Educator is scheduled for the Physical Assessment and Documentation Class; and then provides training on the class to the NCMs and other RNs staff. The Facility continued to use the Health Care Protocols for Developmental Disability Nurses for developing Health Maintenance and Acute Care Plans. Since the last review, Section M.1 Self-assessment and review of training records indicated that the nursing staff had received additional training on developing Health Maintenance Plans and Acute Care Plans. A review of individuals' care plans showed no significant improvement since the last review. In order for this Provision to meet compliance, effectiveness of training must be demonstrated through actual nursing practice sufficient to address the health status of individuals served. Refer to Provision M.3 for more details on these findings. It was positive to find that the Nursing Department continued training the incumbent direct support professionals on the Common Signs and Symptoms of Acute Illnesses and Injuries Curriculum at the New Employee Orientation and at annual refresher training. Training records for this course were turned in to CTD. The percentage of the direct support professionals trained was not available for review. This is an important course 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 this provision to meet compliance, not only must the nursing assessments, reporting protocols, and care plans be established and implemented, and the nursing staff trained; they must be demonstrated through actual clinical practice sufficient to address the health status of individuals served. As was found throughout the other provisions, the assessments, protocols, and care plans have not been adequately put into practice sufficient to meet individuals' health status needs. Therefore, this 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.	

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		The Nursing Department should make the following improvements regarding training: • Ensure that the Nurse Educator receives the mandatory Physical Assessment Class as soon as possible; and then provides training on the class to the NCMs and other RNs. • Ensure that all core nursing policies and protocols and other polices and protocols related to nursing practices are adopted, implemented, and 100% of the nursing staff trained on such, not limited to the associated forms. • Implement training from the competency-based Nursing Education Handbook Manual for New Nurse Orientation and refresher training.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	The Facility's Section M Self-Assessment stated they were not in compliance with this provision and the Monitoring Team concurs. A review of Section M Self-Assessment, Section M Presentation Book, staff interviews and review of documents showed that the Nursing Department had made minimal improvement toward achieving compliance with the requirements contained in this provision. In October, the 2012 Facility's relevant staff had received additional training on the At Risk Individual Policy and associated documents. The Facility had adopted and implemented a revised format for completing the Integrated Risk Rating Form. The revised form included improved instructions for developing rationales to support risk findings. However, at the time of the review, few of the revised Integrated Risk Rating forms had been used for the records reviewed. Of those that were used to complete the Risk Screening Assessments, they typically only included diagnoses, results of diagnostic testing, treatments, and medications; they had not yet provided actual clinical data to support the risk ratings. Ten recently completed At Risk Assessment Screening and Risk Action Plans were reviewed for Individuals #33, #47, #80, #134, #108, #79, #98, #29, #127, and #5. The results of the 10 ten individuals' At Risk Assessment Screenings and Risk Action Plans revealed the following trends: • The quality of the At Risk Assessment Screenings and Risk Action Plans varied from IDT to IDT and from unit to unit. While the rationales for clinical data supporting the decisions for determining risk levels showed improvement from the past reviews, there was a need for continued improvement in both the At Risk Assessment Screenings and Risk Action Plans. • The objectives for the Risk Action Plans were not consistently adequate to functionally measure the efficacy of the plans. • Clinical indicators to be monitored and the frequency were not consistently included or were not adequate to assess progress or lack of progress. • The assessments did not consistently include clinical data from all relevant	Noncompliance

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		disciplines. • The plans failed to consistently include preventative interventions to reduce or eliminate the risk levels. • The plans did not consistently include action steps for all relevant disciplines. Specifically related to nursing services, Risk Action Plans for identified high and medium risk levels did not consistently include action steps for related HMPs. • The plans were not consistently integrated into the ISPs. • The actual date the plans were implemented could not be readily discerned, although they contained implementation dates. Examples included: • Individual #47 had a Risk Screening Assessment completed on 10/19/11 but the Risk Action Plan that should have been developed was either not completed or was not made available in the off-site documents as requested. There was no Risk Screening Assessment available for review in relation to the At Risk Action Plan that was developed on 1/11/12. It was not possible to determine the risk ratings from the Risk Action Plan. A review of the Risk Action Plan did not include clinical indicators to measure the outcome of the action steps for risk ratings. Nursing was not listed as staff responsible for any of the action steps, rather they were assigned to "medical." It could not be determined if this solely indicated it was the medical staff or if it also included nursing staff in with "medical." While nurses work collaborative with the medical staff, nursing is an independent discipline and should be treated as such. Action steps related to specific risk ratings for which the nursing staff have responsibilities should be clearly identified. • Individual #80's physician was not present at the Risk Screening Assessment Meeting on 11/8/11. Because of his complex medical problems the physician should have been in attendance. The Risk Action Plan that should have been developed in relation to the Risk screening Assessment was not available for review. There was no Personal Support Plan Addendum (PSPA) documentation that indicated a plan was developed related to the change in risk ratings. • Individual #33's Risk Screening Assessment completed on 11/28/11, indicated numerous changes from low and medium risks and from medium to high. The accompanying Risk Action Plan was not available for review nor was there documentation in a PSPA that a Risk Action Plan was developed and implemented. • Individual #134's Risk Screening Assessment was completed on 1/2/12, which indicated numerous changes in risk ratings. The accompanying Risk Action Plan was not available for review nor was there documentation in a PSPA that a Risk Action Plan was developed and implemented. Since the last review, the Nursing Department had received additional training on the At	

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		Risk Individuals Policy and Procedures; the review indicated only minimal progress had been achieved toward compliance. The continued need for improvements included: • The Nursing Department should ensure that HMPs are developed and implemented for all high and medium risk levels that require nursing actions/interventions and are incorporated into the Risk Action Plans to include: o Functional and measurable objectives; o Clinical indicators to be monitored and the frequency sufficient to assess the individuals' progress and the effectiveness of the plans; and o Nursing actions and interventions to address the specific high and medium risk levels, including preventive interventions to reduce or eliminate the risk level. • The Facility should ensure that the other disciplines consistently and timely provide the Nurse Case Manager with their clinical risk assessment data to compile into the draft Integrated Risk Rating Forms to take to the ISP and At Risk Assessment and Screening meetings. • The State Office should continue to provide the Nursing Department with technical assistance in defining and clarifying the nurses' role and responsibilities regarding the At Risk Individuals Policy and Procedures.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Facility's Section M Self-Assessment stated they were not in compliance with this provision and the Monitoring Team concurs. Through review of Section M Self-Assessment, Section M Presentation Book, staff interviews and review of documents, there was evidence that the Nursing Department had continued to make steady progress toward achieving compliance in this provision. Since the last review it was positive to find that the Nursing Department had developed and implemented a formalized Medication Administration Observation Process. Some of the activities included the following activities: Each nurse was scheduled to be observed quarterly unless the nurse was placed on probation with a stipulation of bi-monthly observations. A score of less than 90% required the implementation of a CATW2. When completed the CATW2 was submitted to Quality Assurance. A score of less than 85% compliance required an Employee Developmental Note. The overall Medication Administration Observation percentage for compliance, August, 2011 through December, 2011 indicated the following: • August – 97.3% • September – 100% • October – 99% • November – 99% • December – 92% There was documentation that the quarterly Medication Administration Observations for January, 2012 and February, 2012 were in the process of being completed. In January,	Noncompliance

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		2012 the Nursing Department began conducting "spot check" observations. As a result there was documentation that a CATW2 was implemented, completed, and submitted to Quality Assurance. According to Section M Self-Assessment, the Nursing Department planned to complete a retrospective trend analysis of Medication Administration Observations and include the findings at the Pharmacy and Therapeutics Committee meetings. This was a positive step to further evaluate medication administration practices, and should be implemented. There was no process for inter-rater reliability checks in place for Medication Administration Observations. Inter-rater reliability checks are necessary to ensure that the observations made by the Nurse Manager and/or designee accurately reflect the nurses' medication administration performance. The Nursing Department should collaborate with the Quality Assurance Department to develop and implement an inter-rater reliability process for medication. The Nurse Manager and/or designee should be assessed for competency in conducting Medication Administration Observations. The Nurse Monitor and PNM Monitor conducted medication observations in La Paloma and El Paisano for 16 individuals during the 4:00 p.m. medication passes on 2/29/12. The following observations were made: • It was positive to find since the last review, that the Facility had constructed approximately three-foot alcoves on either side of the outside Dutch doors of the medication rooms. While this did not provide complete privacy during medication administration, it did provide some degree of privacy and eliminated crowding of individuals outside the medication room doors. The direct care professionals in La Paloma consistently assisted the nurse administering medications by bringing one individual at a time to the door. The direct care professionals did not provide the same degree of assistance to the nurse administering medications in El Paisano. However, there was no crowding of individuals at the door to cause distractions/disruptions. • The nurse in El Paisano began using both the paper Medication Administration Record (MAR) and the MediMar electronic record system at the beginning of the medication pass, then stopped using the MediMar system and continued to use the paper MAR. The nurse in La Paloma did not use the MediMar electronic system. The paper MAR was used throughout the medication pass. • 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 in past reviews, which included but were not limited to: o The duplicate system increased the time to pass medications. o Often nurses failed to document on the paper copies, which leads to confusion	

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		when monitoring MARs and identifying medication errors. o Because of the time it takes to scan medications into the MediMAR, individuals become restless with the wait and may leave before the medications are 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 could not be accurately checked the on 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. o 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. The failure to consistently document on the MediMar renders this system useless. It only serves to cause confusion, the potential to continue to contribute to medication errors, and increases the time to administer medications. As was recommended in past reviews the Facility should evaluate the risks and benefits of continuing the use of the MediMAR electronic record system. • At past reviews, individuals' pictures in the MARs were so outdated they were hardly recognizable, which had the potential to misidentify individuals and cause medication errors/variances. Since the last review most individuals' pictures had been updated. • Since the last review, the MARs in both La Paloma and El Paisano contained PNMPs with instructions for medication administration. The nurses consistently reviewed the PNMPs for medication administration instructions before administering medications. However, a review of 16 individuals' PNMPs found the instructions for medication administration did not consistently contain all of the information from the dining instructions that promoted safe intake. Nurses were unaware of how certain strategies, e.g., lifting the handle of spoon, can contribute to improper head positioning and thus increase the risk of aspiration. Additionally, as reported in Provision O3, individuals were not consistently provided with a comprehensive medication administration section of the PNMP. This was a pervasive issue. Information contained in the dining section that promoted safe intake was not transferred over to the medication administration section. The PNMP would contain information in the dining section regarding safe intake but this information was lacking in the medication administration section. • The Sippy cups used for specific individuals appeared to contain red residues and did not appear to be properly cleaned. This was discussed with the CNE who explained that the Sippy cups were washed by the nursing staff as opposed to being sent to the kitchen for sanitation. She said the maroon spoons used for medication	

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		administration were sent to the kitchen for sanitation. The CNE immediately sent a directive to the nursing staff instructing them to send the used Sippy cups to the kitchen for sanitizing. • Maroon spoons were only used for individuals at risk for seizures. Otherwise, plastic spoons were used. The safety risk of using plastic spoons with the other individuals who required the use of spoons to administer medications with food was discussed with the CNE. She immediately sent a directive to the nursing staff discouraging the use of plastic spoons. The CNE should have instructed the nursing staff to stop using all plastic spoons for medication administration. To merely discourage the use of plastic spoons sounds like the nurses may pick and choose when to use the spoons. She sent a request to the administrative assistant to order additional maroon spoons of various sizes. • Sixteen of 16 (100%) MARs had all medications administered documented. • Sixteen of 16 (100%) MARs had allergies listed. • Fourteen of 16 (86%) MARs had medical diagnoses listed. • Two of the 16 (13%) individuals had Self-Administration of Medication (SAM) programs. SAM training occurred daily at 7:00 a.m. and 8:00 p.m. Consequently, no training was observed during the 4:00 p.m. medication passes. The nursing staff collected the data and Active Treatment reviewed, analyzed, and documented SAM data one a week. These data were not contained in the MAR. • In addition to conducting medication administration observations, the medication and treatment room were inspected. In both La Paloma and El Paisano all opened medications were dated, no expired medications were found, refrigerators were check daily and were within required temperature range, and the Control Drug Logs contained double signatures at shift to shift change. Inspection of both treatment rooms found electronic and battery operated diagnostic equipment were checked daily and were in good working order. • In El Paisano's treatment room, a drawer of nail clippers was found. Only two of the nail clippers were packaged and labeled for individuals. The nurse was asked how and the frequency the nail clippers were cleaned. She responded they were cleaned with alcohol but did not state frequency they were cleaned or how they were kept separately for each individual. The cleaning procedure was discussed with the ICP and Nurse Educator, who accompanied the Monitoring Team during the medication observation and medication and treatment rooms' inspections. The ICP and Nurse Educator later found the procedure for sanitizing metal instruments. They will procure the proper disinfectant, train the nursing staff on the procedure for sanitizing the nail clippers, monitor to ensure that the procedure is followed, as well as packaging and labeling each individual's nail clippers. This issue will be followed up at the next review. • During a tour of La Paloma on the evening of 2/27/12, a nurse's lunch and opened	

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		container of applesauce was not dated in the medication room's refrigerator. The nurse explained he knew this was not acceptable and promptly removed his lunch and dated the opened container of applesauce. The recently developed State Office Medication Variance Policy, 053 was not in place pending Facility approval. The policy's revised Medication Variance Report form, SC053, was implemented and the nursing staff trained on the form. The Facility should approve and implement the Medication Variance Policy, 053 as soon as possible. This policy includes all aspects of medication administration variances, and is more comprehensive than the Facility's existing Medication Error and Pharmacy Policies. In addition, the policy charges the CNE and/or designee with the responsibility of oversight of the policy. Since the last review, the Facility had improved and refined their Medication Error/Variance Database to track, analyze, and trend medication error/variance utilizing a root cause analysis approach. All items contained on the Medication Variance Reports form were included in the trend analyses. The medication error/variance data was presented in a variety of tabular and graphic charts. Since the last review, the Facility's medication errors/variances reports were separated from the Mental Health and Outpatient Clinics reports. Medication errors/variances were analyzed, trended, and reported at the monthly Medication Management Meetings and quarterly at the Pharmacy and Therapeutic Committee Meetings. Both meetings continued to be combined with the Mental Health and Outpatient Clinic. The First Quarter FY 2012 Trend Analysis (Second Quarter FT2012 Trend Analysis was not available for review) reported the following number and description of medication errors/variances: • A total of 16 medication errors/ variances. • Eight medication errors/ variances occurred in El Paisano. • Eight medication errors/variances occurred in La Paloma. • Highest number (nine or 56%) of medication errors/variances occurred on the 2-10 shift. • Highest number (five or 31%) of medication errors/variances occurred on Wednesdays. • Further analysis and trending of the medication errors/variances included: o Highest number (10) of classifications for Severity Index "C". (A medication variance occurred that reached the individual but did not cause harm.) o Highest number (eight) by node was due to documentation. o Highest number (four) by types of was due to omissions. o Highest number (nine) not identified on investigation. o Highest number (five) of contributing factors was due to distraction. o Highest number (four) of medications involved were lantus insulin and clozaril with two each.	

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		o Highest number (two) committed by an agency staff nurse. A CATW2 was developed and implemented as a result of the above trend analysis that included: • Re-educating the nursing staff on medication administration processes from receiving, transcribing, administering medication, and monitoring individuals' response to the medications, with emphasis on the 2-10 shift. • Renovate the medication rooms to enable privacy during medication passes to decrease distractions. • Identify causes of medication errors/variances upon investigation. This detailed trend analysis with the development and implementation of an accompanying CATW2 was a positive step forward in reducing or eliminating medication administration errors/variances. The Nursing Department's CATW2's for medication errors/variances should identify the responsible staff, projected timeframes for completion, and a resolution date with an evaluation note describing the effectiveness of the CATW2's. The Facility continued to investigate and enter medication errors/variances into the Clinical Workstation (CWS) Medication Error/Variance Database within 5 working days. A review of the notebook containing copies of Medication Error/Variance Reports found that documentation was missing for follow-up and corrective actions. This was discussed with the CNE and the former QA Nurse. When the medication errors/variances were investigated, they were entered into the CWS. The follow-up and corrective actions were included on the final reports. The Nursing Department should ensure that medication errors/variances are discovered promptly, followed up with corrective action, and documented on the Medication Variance Reports. A review of the Medication Management Meeting and Pharmacy and Therapeutic Sub-Committee minutes found that the medication errors/variance trend analyses were reviewed and discussed, except for the 12/21/2011, Pharmacy and Therapeutics Sub-Committee minutes, where only the agenda was available for review. Although the medication errors/variance trend analyses were reviewed and discussed at both meetings, there were no substantive recommendations in the minutes reflecting corrective actions to reduce or eliminate medication errors/variances. The problems identified in previous reports regarding the nursing staff splitting pills, was addressed in the minutes. According to the 9/14/11, Pharmacy and Therapeutics Sub-Committee minutes, when the physicians order medication doses in less than dispensable dosages; the pharmacy will not split the tablets, because this was not acceptable practice. The discussion and outcome by the committee found, "It is pharmaceutically acceptable to have nursing split once scored tablets, when physician gives orders. Nursing can order	

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		and have on hand several pill cutters in each Unit, which will resolve the contamination of powder spilling if only one cutter was used for multiple patients". Splitting tablets, even if scored once, is not an acceptable standard of medication administration practice for the nursing staff, even if the committee approved. The State Office Pharmacy Coordinator should further evaluate the practice of the nursing staff splitting tablets for acceptable practice. The minutes noted that Medication Administration Variance Policy, 053, had not been adopted and implemented pending the approval of the Nursing Manual. As stated above, this policy includes all aspects of medication administration variances, and is more comprehensive than the Facility's existing Medication Error and Pharmacy Policies. In addition, the policy charges the CNE and/or designee with the responsibility of oversight of the policy. The Facility should approve and implement the Medication Variance Policy, 053, as soon as possible. Although there had been some improvements made, this provision was not found in compliance; the Facility should maintain the positive practices identified in the report and make improvements on the following practices: • The Nurse Manager and/or designee should be assessed for competency in conducting Medication Administration Observations. • The Nursing Department should collaborate with the Quality Assurance Department to develop and implement an inter-rater reliability process for Medication Administration Observations. • The Nursing Department should collaborate with the PNMT for additional training on individuals' PNMPs regarding specific instructions for medication administration. The PNMT medication administration instructions should include not only 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, adaptive equipment, and intake strategies. Refer to Section O, Provisions O.3 and O.5 for additional information regarding this issue. • The Nursing Department should ensure all nursing staff are provided with enhanced dysphagia training e.g., the State Office dysphagia training. The Nurse Manager and/or designee who conduct Medication Administration Observations should also receive the dysphagia training • The Nursing Department should ensure that personal food is not stored in the medication room refrigerator and that all open food containers are dated. • The Nursing Department should ensure that individuals' personal care items, such as nail clippers, are properly cleaned/sanitized and stored separately. • The Nursing Department should ensure that medication errors/variances are discovered promptly, followed up with corrective action, and documented on the Medication Variance Reports.	

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		• The Nursing Department's CATW2's for medication errors/variances should identify the responsible staff, projected time frames for completion, and a resolution date with an evaluation note describing the effectiveness of the CATW2's. • The Facility should approve and implement the Medication Variance Policy, 053, as soon as possible.	

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

1. The Nursing Department should ensure that the recently hired Infection Control Nurse, Unit Nurse Manager, and Nurse Educator are thoroughly trained and demonstrate competency in their respective roles and responsibilities. (Provision M.1)
2. The Nursing Department should re-train all nursing staff in policies and protocols relating to the assessment and documentation of individuals with acute changes in status. (Provision M.1)
3. The Nursing Department should review the Nursing Assessment in Acute Situation Policy for clarification regarding method of transporting individuals who are experiencing medical emergencies, and the nursing staff trained to ensure they know when to call 911 or EMS for transport. (Provision M.1)
4. Nursing Department should adopt and implement the Nursing Protocol: Hospitalizations, Transfers and Discharges to ensure that the nursing staff are adequately trained to meet all the relevant requirements for managing individuals who require hospitalization. (Provision M.1.)
5. The Nursing Department should: (Provision M.1)
   - Ensure that the nursing staff complete the Infection Report when infections are diagnosed and submit the report promptly to the ICP for real-time follow-up investigations.
   - Ensure that the ICP implements a formal process for checking the reliability of infection reports.
   - Ensure that the Nurse Educator monitors all protocols for nurses' competencies and that they are followed as specified.
   - Ensure that the ICP collaborates with the nursing staff on the development and implementation of ACPs and HMPs for acute and chronic infections to ensure they are clinically appropriate and include preventative interventions.
   - Ensure the ICP collaborates with physicians regarding performing culture and sensitivity studies for relevant infections to ensure the most effective antibiotics are prescribed.
   - Ensure ICP collaborates with the Safety/Risk Management/Infection Control Committee to explore causative/contributing factors leading to the reported infection rates and make recommendations for corrective action to reduce or eliminate the reported infections.
   - Ensure the ICP makes every effort to obtain a current Antibiogram and Antibiotic Susceptibility of Common Organisms Reports common to the Rio Grande area to ensure the most effective antibiotic therapies are prescribed to treat infections.
   - Ensure the ICP reviews the Antibiogram and Antibiotic Susceptibility of Common Organisms Report with the Pharmacy and Therapeutics Committee to ensure that susceptibility/effectiveness of the antibiotic therapy prescribed, as required by the Settlement Agreement. (Provision M.1)
6. The Facility should continue to explore with the Life Safety Committee and DADS the use of portable suction machines in areas on campus where it is not feasible to use an electric suction machine, e.g., the Vocational Services area and campus grounds. (Provision M.1)
7. The Interim Vocational Services Manager should ensure that the Campus Coordinators complete monthly Emergency Equipment Walkthrough Checklists. (Provision M.1)
8. The Nursing Department and Interim Vocational Services Manager should ensure that all required emergency equipment is checked daily for proper working order, oxygen tanks checked for an adequate supply of pressure, and missing and/or expired equipment replaced. (Provision M.1)
9. The Nurse Educator should ensure that all nurses are trained on the revised Emergency Response Policy and emergency equipment. (Provision

M.1)

10. The Nursing Department should ensure that all Nursing Care Monitoring Tools are completed according to schedule, sent to the Quality Assurance Department to enter into the Quality Assurance Database, analyzed, and trended for compliance. For the tools falling below 90%, systemic CATW2s should be developed, implemented, and followed through to resolution. (Provision M.1)
11. The Nursing Department should ensure the following: (Provision M.2)
    - The Nurse Case Managers complete an addendum to the Quarterly Comprehensive Nursing Assessment when there are changes in individuals risk ratings or other significant changes in health status and revise and/or develop and implement HMPs for changes in status.
    - The Nurse Managers summarize each nursing problem/diagnosis separately for clarity.
    - Adopt and implement the revised DADS Nursing Protocol: Hospitalizations, Transfers and Discharges, Dated 6/2011
    - The Nurse Case Managers avoid writing nursing summaries in capital letters and long run-on statements.
    - Adopt and implement the revised Admission and Discharge to Community or Other Facilities Nursing Assessment format, including a section for special discharge instructions, and train the Nurse Case Managers.
    - Schedule the Nurse Educator for the mandatory Physical Assessment and Documentation Class. Then, train the Nurse Case Managers and other RNs.
12. The Nursing Department Should ensure the following: (Provision M.3)
    - HMPs address all high and/or medium risk indicators and active problems that require nursing interventions.
    - HMPs are individualized to meet individuals' specific health care needs in relation to their identified risks and/or active medical problems.
    - HMPs are reviewed and/or revised at the time of the quarterly/annual nursing assessment or when there was a change in health status.
    - ACPs and HMPs include proactive/preventative measures to reduce and/or eliminate risk indicators/problems.
    - ACPs and HMPs contain integrated interventions in collaboration with other relevant disciplines, as required in Sections G and F of the Settlement Agreement.
    - ACPs and HMPs include who would implement the nursing interventions, how often they would be implemented, where they were documented, and how often they would be reviewed and/or revised.
13. The Nursing Department should make the following improvements regarding training: (Provision M.4)
    - Ensure that the Nurse Educator receives the mandatory Physical Assessment and Documentation Class as soon as possible, and provide training on the class to the NCMs and other RNs.
    - Ensure that all core nursing policies and protocols and other polices and protocols related to nursing practices are adopted, implemented, and 100% of the nursing staff trained on such, and not limited to the associated forms.
    - Implement training from the competency-based Nursing Education Handbook Manual for New Nurse Orientation and refresher training.
14. The Nursing Department should ensure that HMPs are developed and implemented for all high and medium risk levels that require nursing actions/interventions and are incorporated into the Risk Action Plans to include: (Provision M.5)
    - Functional and measurable objectives;
    - Clinical indicators to be monitored and the frequency sufficient to assess the individuals' progress and the effectiveness of the plans; and
    - Nursing actions and interventions to address the specific high and medium risk levels, including preventive interventions to reduce or eliminate the risk level.
15. The Nursing Department needs to continue improvements in the following areas of medication administration: (Provision M.6)
    a. The Nurse Manager and/or designee should be assessed for competency in conducting Medication Administration Observations.
    b. The Nursing Department should collaborate with the Quality Assurance Department to develop and implement an inter-rater reliability process for Medication Administration Observations.
    c. The Nursing Department should collaborate with the PNMT for additional training on individuals' PNMPs regarding specific instructions for medication administration. The PNMT medication administration instructions should include not only 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, adaptive equipment, and intake strategies.

d. The Nursing Department should ensure all nursing staff are provided with enhanced dysphagia training e.g., the State Office dysphagia training. The Nurse Manager and/or designee who conduct Medication Administration Observations should also receive the dysphagia training.
e. The Nursing Department should ensure that personal food is not stored in the medication room refrigerator and that all opened food containers are dated.
f. The Nursing Department should ensure that individuals' personal care items, such as nail clippers, are properly cleaned/sanitized and stored separately.
g. The Nursing Department's CATW2's for medication errors/variances should identify the responsible staff, projected time frames for completion, and a resolution date with an evaluation note describing the effectiveness of the CATW2's.
h. The Nursing Department should ensure that medication errors/variances are discovered promptly, followed up with corrective action, and documented on the Medication Variance Reports.

The following are offered as additional suggestions to the Facility:

1. The Facility and/or State Office should consider providing the Nursing Department with technical assistance from an expert to provide competency-based training to assist the relevant nursing staff with critically analyzing clinical data into clear and concise summaries reflective of individuals' health status. (Provision M.2)
2. The Facility should ensure that the other disciplines consistently and timely provide the Nurse Case Manager with their clinical risk assessment data to compile into the draft Integrated Risk Rating Forms to take to the ISP and At Risk Assessment and Screening meetings. (Provision M.5)
3. The State Office should continue to provide the Nursing Department with technical assistance in defining and clarifying the nurses' role and responsibilities regarding the At Risk Individuals Policy and Procedures. (Provision M.5)
4. The Facility should evaluate the risks and benefits of continuing the use of the MediMAR electronic record system. (Provision M.6)
5. The Facility should approve and implement the Medication Variance Policy, 053, as soon as possible. (Provision M.6)
6. The practice of the nursing staff splitting tablets should be further evaluated for acceptable practice by the State Office Pharmacy Coordinator. (Provision M.6)

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 Self-Assessment and Action Plan 2/13/12 2. RGSC Section N Presentation Book 3. Standard Operating Procedure, PH100-045-01-02 – Drug Regimen Reviews, dated March 2011. 4. Adverse Drug Reaction (ADR) Report and Evaluation Form, Standard Operating Procedure NR100-67, dated December 1998, updated December, 2008 5. First ten medication orders written in February that did not require a single patient intervention 6. Physician Communication Form 7. The most recent two Quarterly Drug Regiment Reviews (QDRRs), active problem list, current medication list, past 12 months of labs, all EKGs from the past two years, the annual medical review, past 12 Months MOSES and DISCUS assessments, and any evidence to support that the physician followed recommendations, for the following Individuals #101, #79, #26, #96, #48, and #72 8. Polypharmacy Workgroup Minutes, 8/8/11 & 8/24/11 9. Polypharmacy Agenda, 8/24/11 10. Pharmacy and Therapeutics (P&T) Sub-Committee Meeting Minutes, 12/21/11 11. QDRRs, problems lists, QDRR worksheets, 12 months labs for Individuals #54, # 5, #150, #33, and #108 12. Most recent two MOSES and DISCUS and last QDRR for Individuals #80, #149, #35, #5, and #97 13. Face-to-Face Assessment, restraint checklist, clinical records, and incident management meeting minutes for Individual #15. 14. DADS Policy 053, Medication Variances, dated 9/23/11 15. Facility's Medication Error Policy, revised December 2007 16. RGSC Blank Medication Variance Report Form 17. RGSC Medication Management Workgroup Notes, 11/29/11, 12/27/11, and 1/24/12 18. RGSC Pharmacy and Therapeutic Sub-Committee Meeting Minutes 9/14/11 and 12/21/11 **People Interviewed:** 1. Yolanda Gonzalez, RN, CNE 2. Luis T. Lester. R.Ph 3. Anne Ikponmwomba, R.Ph 4. Kenda Pittman. R.Ph 5. Linda Lothringer 6. David Moron, MD 7. Mary Ramos, QM Director 8. Jessica Galindo Juarez, Infection Control Preventionist (ICP) **Meeting Attended/Observations:** 1. Observation of Individuals #80, #149, #35, #5, #97
	Facility Self-Assessment:

	The Facility reported noncompliance for Provisions N1 through N8, which is consistent with the Monitoring Teams assessment. The Self-Assessment (SA) and action steps mostly reflect a list of what the Facility has reviewed while working towards compliance but does not outline what steps are necessary to achieve compliance. Specifically, the SA for Provision N1 reports that the Facility had updated and implemented policies related to drug utilization and adverse drug reactions; however, Provision N1 is specific for medication review of new medication orders, and the self-assessment did not identify how the policy is intended to affect that. The SA for Provision N2 only indicates that the Facility is focusing on ensure timeliness of QDRRs and that pharmacists rely on the QDRR worksheets to ensure that monitoring parameters were implemented. Compliance for Provision N2 requires that QDRRs are conducted according to generally accepted standard practice, and is not limited to the worksheet parameters. SA N3 only comments on stat medications, however, the Provision calls for the monitoring of benzodiazapines, anticholinergics, and metabolic syndrome, as well as polypharmacy and stat medications. The self-assessments for Provisions N4 though N8 appear appropriate, and if implemented, may lead to compliance.
	Summary of Monitor's Assessment: Provision N1: The Monitoring Team determined that the Facility did not have an effective process to ensure that the pharmacist comprehensively reviews all new medication orders, and that appropriate diagnostics are reviewed, as clinically necessary, prior to dispensing medication. For these reasons, the Monitoring Team determined that the pharmacy remains not in compliance and has made no improvements towards compliance for Provision N1. Provision N2: Because the requested information (including current medication lists and active problem lists for all sampled individuals) was not provided by the Facility, the Monitoring Team was not able to assess compliance for Provision N2, of the Settlement Agreement hence, the Facility remains not in compliance. Provision N3: The Facility does not have appropriate policies, procedures, or practices to effectively manage or provide the necessary oversight for the use of polypharmacy, Stat medication use, including chemical restraints and benzodiazepines. The pharmacy department does not provide the necessary monitoring and oversight of metabolic syndrome, and therefore is not compliant with Provision N3. The Facility must develop and implement the necessary policies, procedures, and practices to ensure appropriate oversight of the use of Stat medications, chemical restraint, polypharmacy, benzodiazepines, and metabolic syndrome. Provision N4: Because the pharmacy department does not have an effective process to ensure appropriate physician action plan, or process to follow-up on pharmacy recommendations made to physicians, the Facility remains not in compliance with provision N4. Provision N5: Because elevated DISCUS scores were not adequately represented on the QDRR, and

	appropriate pharmacy recommendations to the physician were not documented on the QDRR, the Monitoring Team determined that the Facility is not in compliance with Provision N5. Provision N6: Because the Facility did not have effective policies, procedures, and practices for managing ADRs, the Monitoring Team determined that the Facility remains not in compliance with the Provision. The Facility must develop, and when necessary update, specific policies and procedures that reflect the Facility's management of ADRs. The Facility must perform a comprehensive review of each ADR in the context of the individual, and also in the context of how the ADR might affect other individuals in the future. The Facility must also ensure a robust evaluation in the form of trends analysis, with summary and appropriate recommendations by pharmacy. It should be noted that the reported total of three ADRs during the reporting period is questionable. Based on the number of individuals at the Facility, the average age on individuals served at the Facility, and the number of medications prescribed, more then three ADRs would be expected.. Provision N7: 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. The Monitoring Team determined that the Facility is not in compliance with Provision N.7, of the Settlement Agreement Provision N8: The Monitoring Team determined that the Facility remained noncompliant with Provision N8, and compliance will require pharmacy to lead efforts to ensure that the Facility adopts and implements the DADS Policy for Medication Variances, and that a well integrated process is developed that ensures physician, pharmacy, and nursing services work collaboratively in identifying, reporting, analyzing, and determining remedial action and follow-up for all prescribing, dispensing, administration, and storage variances.

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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	To determine compliance with Provision N.1, the Monitoring Team requested all policies and procedures associated with reviewing medication orders, reviewed the Physician Communication Form and the first ten prescriptions written in February, 2012, that did not require a single patient intervention report. The Monitoring Team was provided a policy and procedure entitled Standard Operating Procedure, PH100-045-01-02 – Drug Regimen Reviews, dated March 2011. Following	Noncompliance

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	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.	review of the procedure, the Monitoring Team determined that the procedure did not clearly delineate the process necessary to adequately review new medication orders, as it did not comment on how orders that do not require interventions are tracked to ensure that the pharmacist reviewed the order for conditions outlined in Provision N1. Although the Monitoring Team clearly requested that the Facility provide documentation demonstrating pharmacy review of medication orders completed that did not require a single patient intervention, the Facility instead provided medication orders that did require a single patient intervention. Therefore, because the Facility did not provide documentation of review of other medication orders, the Monitoring Team could not confirm that all required items were reviewed. The Monitoring Team has reviewed the screens for the WORx program for entering medication orders; it includes an individual profile, allergy alerts, and drug-drug intervention alerts as well as duplications. However, there is no documentation to ensure the pharmacist attended to this information. Conclusion: The Monitoring Team determined that the Facility did not have an effective process to ensure that the pharmacist comprehensively reviews all new medication orders, and that appropriate diagnostics are reviewed, as clinically necessary, prior to dispensing medication. For these reasons, the Monitoring Team determined that the pharmacy remains not in compliance and has made no improvements towards compliance for Provision N1.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	The Monitoring Team understands the importance of the Quarterly Drug Regimen Review (QDRR) process, and as a component of it's review for Provision N.2, the Monitoring Team also assessed to ensure that the Facility QDRR process meets generally acceptable standard of care practice. To evaluate the QDRR the Monitoring Team requested the most recent two QDRRs, active problem list, current medication list, past 12 months of labs, all EKGs from the past two years, the annual medical review, past 12 Months MOSES and DISCUS assessments, and any evidence to support that the physician followed recommendations, for the following Individuals #101, #79, #26, #96, #48, and #72. Upon review, it was noted that documents for none of the individuals requested included a current medication list, which the Monitoring Team required for its review of the QDRR process. Also, Individual #96 did not include an Annual medical review or problem list; Individuals #79 and #26 did not include a current problem list; and no information was provided for Individual #48.	Noncompliance

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		Conclusion: Because the requested information was not provided by the Facility, the Monitoring Team was not able to assess compliance for Provision N2, of the Settlement Agreement; hence, the Facility remains not in compliance.	
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.	To assess compliance for Provision N.3, the Monitoring Team reviewed clinical records, and met with the pharmacy director about their monitoring of Stat medications, chemical restraints, polypharmacy, use of benzodiazepines, and metabolic syndrome. <u>Stat Medications/Chemical Restraint</u> The pharmacy department did track the use of Stat medications, including Stat medication used as chemical restraint. The Monitoring Team, along with the Director of Pharmacy, reviewed the pharmacy's Stat medication data. The data elements were complete; however, the pharmacy did not routinely provide a data analysis and summary of each use of a chemical restraint. Compliance for Provision N3 requires that the pharmacy provide a meaningful review and summary of the use of Stat medications that will ensure they are used in a clinically justifiable manner and not as a substitute for long-term treatment. The Monitoring Team request all information used by the Facility for all chemical restraints administered since the last review. The Monitoring Team was informed that one individual was provided a chemical restraint; the Facility provided the Face-to-Face Assessment, restraint checklist, and incident management meeting minutes for Individual #15. The Monitoring Team also reviewed the clinical record of this individual. The Incident Management Review Team meeting minutes reflected that the Facility identified a procedural failure, of not following Facility policy, and took remedial steps to address the issue. The Monitoring Team compliments the Facility for this action; however, the clinical rationale was not addressed, nor were recommendations made regarding the use of chemical restraints in the future. The Face-to-Face Assessment was determined by the Monitoring Team to be ineffective, and did not provide for a meaningful clinical review of the use of the chemical restraint because the pharmacist and psychiatrist did not provide details as whether the use of a chemical restraint was justifiable, noting drug-drug interactions, and whether the maintenance medication needed to be adjusted. <u>Polypharmacy</u> The Monitoring Team is most concerned is that the Facility's polypharmacy committee had not met, since October 24, 2011. Therefore, there was no ongoing facility-wide review of clinical appropriateness of use of polypharmacy, no review of trends in usage,	Noncompliance

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		and no planning to identify and reduce unnecessary use of polypharmacy. According to the pharmacist, the pharmacist runs a report for polypharmacy, and utilizes the report when completing QDRRs. The pharmacy did not perform a trends analysis or generate a summary for committee review. Importantly, when considering polypharmacy, the pharmacy department was unaware that the Settlement Agreement considers all neuroleptics to be considered as polypharmacy if two or more are administered. Review of the Facility's Polypharmacy Workgroup Minutes, dated 8/8/11, and 8/24/11, indicated that the Facility reviews a predetermined number of individuals who were identified as being on polypharmacy. Not all individuals on polypharmacy are reviewed monthly; given the lack of monthly meetings, that would indicate not all individuals on polypharmacy are likely to have had a review.. In addition, the Facility did not have a process to evaluate polypharmacy system-wide by means of trends analysis. The Facility continued to utilize significant polypharmacy. For example, at the time of this review, a total of 19, out of 72 individuals (26%), were prescribed two or more antipsychotic medications, which is considered to be significant polypharmacy by generally accepted standard of care for Individuals with Developmental Disabilities. The Facility must enhance its effort to monitor the use of polypharmacy. Pharmacy must not only collect data, it must analyze the data for trends and provide a meaningful summary, along with clinical recommendations for the pharmacy and therapeutic committee to review. The P&T committee must carefully assess the Facility's use of polypharmacy, and make systematic, as well as individual recommendations. All recommendations must be tracked for efficacy and completeness. <u>Benzodiazepines</u> The Clinical Director informed the Monitoring Team that the Facility began tracking the use of benzodiazepines at the Facility, but had not yet begun a process to conduct a trends analysis, or provide a specific summary of benzodiazepine use. There were no comments about benzodiazepine use in previous polypharmacy, or medication management committee meeting minutes, provided to the Monitoring Team. The Facility must begin a meaningful process of not only collecting data on the use of benzodiazepines, but conduct a comprehensive review and analysis of the use of benzodiazepines, and ensure that the data, data analysis and summary, along with recommendations are made to the P&T committee, and that the committee carefully review and make recommendations on any systemic issue.	

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		Metabolic Syndrome The Monitoring Team reviewed completed QDRR's on individuals who were diagnosed with diabetes, or had a diagnosis of hyperlipidemia and were on psychotropic medications. • Individual #33 Information required for review was not available. The Monitoring Team requested two most recent QDRRs, and only one was provided. Current medication list was not provided. There was no indication that metabolic syndrome was assessed. • Individual #150 QDRR worksheet indicated risk factors for metabolic syndrome. QDRR form only stated, "risk for metabolic syndrome". The individual is a diabetic, with significant risks for metabolic syndrome, and is on two neuroleptics. The pharmacist did not stress these issues or make necessary recommendations for the physician. • Individual #5 Individual is diabetic, has hyperlipidemia, is on two neuroleptics, and QDRR did not comment on these issues or recommend action plan. • Individual #108 Individual was known to be a diabetic, and had hyperlipidemia. The QDRR worksheet indicated that the individual was at risk for metabolic syndrome. The QDRR worksheet indicated that blood pressure (B/P) was not in chart, so did not review B/P. To make an appropriate assessment for the risk of metabolic syndrome, the B/P must be noted. There was no comment about the risk of metabolic syndrome on the QDRR. • Individual #54 The Pharmacist documented on the QDRR "Pt is at low risk for metabolic syndrome because risk managed with current regimens". The Monitoring Team noted that the Individual was prescribed two neuroleptics, which can also predispose to metabolic syndrome. The Monitoring Team would like to comment that based on the risk factors, the Individual had metabolic syndrome, so could not be at a low risk. Based on the review of the five samples, the Monitoring Team determined that the pharmacy department did not address metabolic syndrome assertively. The Facility must enhance its process to ensure that assessment of metabolic syndrome addresses all important issues including relevant clinical factors and signs once diagnosed, medications which have side effects that predispose toward metabolic syndrome, and appropriate rating of risk in light of risk factors and current health status. Conclusion: The Facility does not have appropriate policies, procedures, or practices to effectively manage or provide the necessary oversight for the use of polypharmacy, Stat medication	

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		use including chemical restraints, and benzodiazepines. The pharmacy department did not provide the necessary monitoring and oversight of metabolic syndrome, and therefore is not compliant with Provision N3. The Facility must develop and implement the necessary policies, procedures, and practices to ensure appropriate oversight of the use of Stat medications, chemical restraint, polypharmacy, benzodiazepines, and metabolic syndrome.	
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.	To assess pharmacy's ability to follow-up on recommendations made by the pharmacy, the Monitoring Team reviewed the most recent QDRRs for Individuals #54, # 5, #150, #33, and #108, and met with the director of pharmacy. Review of QDRRs for Individuals #54, # 5, #150, #33, and #108 indicated that physicians do not document their own action plan on the QDRR; the pharmacist is required to review, accept and monitor this plan for completion. The director of pharmacy informed the Monitoring Team that the pharmacy does follow-up on all recommendations and physician action plans and maintains a separate record in the department of pharmacy that includes follow-up results. The Monitoring Team independently reviewed the pharmacy files for Individuals #33, #139, #77, #35, #76, and #150, and determined that no evidence was available to support the pharmacist maintaining adequate evidence to support that the physician followed through with the recommended action plan. Importantly, there is no documentation process or policy that delineates how the pharmacy ensures concurrence with the physician plan and follow-up to completion. Conclusion: Because the pharmacy department did not have an effective process to ensure appropriate physician action plan, or a process to follow-up on pharmacy recommendations made to physicians, the Facility remains not in compliance with provision N4.	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 or DISCUS), of tardive dyskinesia.	To assess the Facility's effort to ensure the effective use of the MOSES and DISCUS screening tools, the Monitoring Team request the MOSES, DISCUS, and QDRR for Individuals #80, #149, #35, #5, #97 (who were observed as having abnormal movements) and met with the director of pharmacy. The director of pharmacy informed the Monitoring Team that for every abnormal DISCUS and MOSES, the pharmacy will send the physician a single patient intervention, and review and document relevant issues at the time of conducting QDRRs. The Monitoring Team noted elevated total DISCUS scores for Individuals #80, #149, #35, #5, and #97. Upon review of the QDRRs, the Monitoring Team noted only one noted the	Noncompliance

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		risk of tardive dyskinesia and provided excellent recommendations to the physician (Individual #97); however, there was no indication of an action plan to address the abnormal DISCUS, with the exception of the primary care physician documenting "notified psychiatrist." The QDRRs for Individuals #80, #149, #35, and #5, did not document abnormal DISCUS findings. Hence, only one out of five samples (20%) appropriately documented and made recommendations to address elevated DISCUS scores. Conclusion: Because elevated DISCUS scores are not adequately represented on the QDRR, and appropriate pharmacy recommendation to the physician were not documented on the QDRR, the Monitoring Team determined that the Facility is not in compliance with Provision N5.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	To assess the Facility's ability to manage Adverse Drug Reactions (ADRs), the Monitoring Team requested all local policies that address ADRs; policy and procedure for training staff on ADRs; copy of ADR training materials for staff; and copy of all ADR reports, documents, trends analysis, facility reviews for the last five ADRs. The Monitoring Team was provided with a local Facility policy on ADRs, entitled Adverse Drug Reaction Report and Evaluation Form, Standard Operating Procedure NR100-67, dated December 1998, updated December, 2008. The policy was determined to be insufficient by the Monitoring Team because it did not reflect the broad activities that the Facility is responsible for, when managing ADRs. Based on review of the P&T sub-committee meeting minutes, dated December 21, 2011, the Monitoring Team determined that the Facility only reported on three ADRs by providing the manifestation of the ADR and suspected drug. Pharmacy did not provide a detail analysis of the ADRs, or make recommendations regarding the ADRs. The Facility must understand the nature of each ADR and how it impacted the individual, and how it may impact other Individuals at the Facility. The Pharmacy is responsible to conduct a comprehensive trends analysis on each ADR and provide a summary of the analysis. It is also important to use trends analysis looking at how a similar ADR may have impacted the individual and the Facility as a whole. According to what was provided to the Monitoring Team for review, for the previous six-month period, the Facility only reported a total of three ADR's and reported on ADRs one time, on December 21, 2011. The Monitoring Team was pleased to note that a comprehensive training program was provided to direct care and nursing staff at the Facility. The Facility reported that it only experienced a total of three ADRs during the previous	Noncompliance

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		six-month period; however, only one ADR report was provided to the Monitoring Team for review (Individual #36). The only document provided was the step #1, Nurse's Section; hence, the Monitoring Team was unable to assess the completeness and appropriateness of the Facility' documentation of ADRs. Conclusion: Because the Facility did not have effective policies, procedures, and practices for managing ADRs at the Facility, the Monitoring Team determined that the Facility remains not in compliance with the Provision. The Facility must develop and, when necessary, update specific policies and procedures that reflect the Facility's management of ADRs. The Facility must perform a comprehensive review of each ADR in the context of the individual, and also in the context of how the ADR might affect other Individuals in the future. The Facility must also ensure a robust evaluation in the form of trends analysis, with summary and appropriate recommendations by pharmacy. It should be noted that a total of 3 ADRs during the reporting period is questionable. Based on the number of individuals at the Facility, the average age on individuals served at the Facility, and the number of medications prescribed, more then three ADRs would be expected.	
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 Facility reported that it continues to work on a draft policy for its development of a Drug Utilization Evaluation (DUE) program. The Facility conducted DUEs very differently then 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 reviews 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. Issues identified during the DUE were reported on the QDRR, for physician review. 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 based 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. Conclusion: 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	Noncompliance

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		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 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.	To assess the Facility's process addressing medication variances, the Monitoring Team met with the Clinical Director, and Director of Pharmacy, and reviewed the Facility's Policy and procedures on medication variances, including the DADS Policy 053, Medication Variances, dated 9/23/11, and the Facility's Medication Error Policy, revised December 2007. In addition, a blank Medication Variance Report Form, Medication Management Workgroup Notes, 11/29/11, 12/27/11, and 1/24/12,and the Pharmacy and Therapeutic Sub-Committee Meeting Minutes 9/14/11 and 12/21/11were reviewed. The Monitoring Team also reviewed Provision M8, of this report. Per Provision M8 of this report, and review of Medication Management Workgroup Notes and P&T Sub-Committee Meeting Minutes, the Monitoring Team noted that a total of 16 medication variances were reported by nursing staff, and that nursing staff had made significant improvement with better identification, reporting and analyzing medication variances. The Facility's medication variance process, however, did not include a collaborative effort among physician, pharmacy and nursing services. In fact, physician services were not actively engaged in the medication variance process, in identifying and reporting on medication variances caused by physicians. Importantly, the Facility had not integrated or implemented the DADS policy on medication variances, and did not specifically address prescribing, dispensing, administration, and storage variances through an integrated process. Conclusion: The Monitoring Team determined that the Facility remained noncompliant with Provision N8, and compliance will require pharmacy to lead efforts to ensure that the Facility adopts and implements the DADS Policy for Medication Variances, and that a well integrated process is developed that ensures physician, pharmacy, and nursing services work collaboratively in identifying, reporting, analyzing, and determining remedial action and follow-up for all prescribing, dispensing, administration, and storage variances.	Noncompliance

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

1. Develop a mechanism that ensures that the Pharmacist has appropriately reviewed all new medication orders for issues required by Provision N1. (Provision N1)
2. Pharmacy must track and trend all Stat medications and provide trends analysis summary for the systemic use Facility wide and the Individual use of Stat medications, including the use for chemical restraint. (Provision N3)
3. The Facility must enhance completion of Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint. This report should reflect a careful analysis, along with recommendation for each chemical restraint. The pharmacist and psychiatrist must discuss how and why the medication was used, if it was justifiable in their opinion, what potential risks may have occurred vs. risk of not providing the medication, and other recommendations. (Provision N3)
4. The Facility must improve its management of polypharmacy, and ensure that a robust committee is in place to routinely monitor, assess and make clinical recommendations to minimize polypharmacy when clinically appropriate. The Facility must conduct and analyze trends data to assess system issues related to polypharmacy at the Facility – provision. (Provision N3)
5. The Facility must enhance its process to ensure that assessment of metabolic syndrome addresses all important issues including relevant clinical factors and signs once diagnosed, medications which have side effects that predispose toward metabolic syndrome, and appropriate rating of risk in light of risk factors and current health status. (Provision N3)
6. Ensure that a documentation and tracking mechanism is developed and implemented to ensure that physicians adhere to pharmacy recommendation, or provide clinical rational for not following pharmacy recommendations, and that physician action plan is followed by the pharmacy through completion. (Provision N4)
7. Immediately ensure that the Facility performs DISCUS and MOSES screening tools routinely, and more frequently when necessary. Also, ensure that abnormal DISCUS and MOSES result are well documented at the time of conducting QDRRs, and that appropriate recommendations are provided to the physician – N5
8. Develop and implement policies and procedure for managing ADRs at the Facility. (Provision N6)
9. Ensure that pharmacy conducts a comprehensive analysis of each ADR and its impact on the Individual, and potential impact to others. Pharmacy must also report on trends analysis for past ADRs at the Facility. (Provision N6)
10. The Facility must enhance its DUE process to reflect recommendations made in Provision N.7, of this report. (Provision N7)
11. The Facility must integrate and implement the DADS policy for Medication Variances. (Provision N8)

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: 1. RGSC Plan of Improvement (POI), dated 2/13/12 2. Record reviews: a. Sample 1: Individuals #29, #46, #76, #97 and #108 b. Sample 2: Individuals #29, #36, #47, #48, #57, #79, #82, #98, #108, #113, #115, #121, #143, and #150 c. Sample 3: Individuals #47, #79 and #126 d. Sample 4: Individuals #26, #97, and #121 e. Sample 8: Individuals #11, #13, #19, #29, #35, #66, #67, #74, #76, #77, #85, #94, #97, #108, #115, and #139 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. PNMT process (local policy) 2/2/12 5. A list of continuing education sessions or activities participated in by PNMT members since last compliance visit (8/2011) 6. Minutes, including documentation of attendance, for the PNMT meetings for the past 4 months 7. Individual PNMT reports as available for individuals reviewed above 8. Tools used to screen and identify individuals' PNM health risk level 9. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order 10. Tools used to assess PNM status and needs 11. A list of PNM assessments and updates completed in the last two (2) quarters 12. PSPs for the sample individuals 13. Completed Physical Nutritional Management Plans (PNMPs) for all sample individuals 14. Tools used to monitor implementation of PNM procedures and plans 15. 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 16. Nutritional management plan template and any instructions for use of template 17. Dining Plan template 18. PNM spreadsheets generated by the Facility 19. Training records that occurred in response to diet downgrades 20. Lists of individuals: a. On modified diets/thickened liquids; b. Whose diets have been downgraded (changed to a modified texture or consistency) during the past 12 months; c. With BMI equal to greater than 30; d. With BMI equal to less than 20; e. Since August 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 21. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation since the last review 22. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials 23. Tools and checklists used to provide competency-based training addressing: a. Foundational skills in PNM; and b. Individual PNM and Dining Plans 24. Since the last review, a list of competency-based training sessions addressing foundational skills in PNM 25. Aspiration Trigger Data Sheets for individuals who are at a moderate or high risk of aspiration 26. Monitoring Forms completed over the past two months 27. Dining Plans and PNMPs for Individuals who had undergone a MBSS from September 2011 to January 2012 28. Morning Team minutes for identified samples listed above **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. Marcy Valdez RN 6. Lorraine Hinrichs 7. Five direct care staff (3 La Paloma and 2 El Paisano) **Meeting Attended/Observations:** 1. PNMT meeting 2/28/12 2. La Paloma lunch and dinner 3. El Paisano lunch and dinner 4. Las Paloma and El Paisano transition times 5. Medication Administration 2/28/12 La Paloma and El Paisano
	Facility Self-Assessment: RGSC Self-Assessment, updated 2/13/12, provided comments/status for Sections O.1 through O.8 of the

	Settlement Agreement. The Facility indicated it was not in compliance with Provisions O.1, O.2, O.3, O.4, and O.6 and in compliance with Provision O.5. This was inconsistent with the Monitoring Team's findings as all provisions were found to be noncompliant. RGSC stated O.5 was in substantial compliance because the process of monitoring DCPs to ensure staff is competently trained. The Monitoring Team determined this provision was not in compliance due to lack of competency based training for all aspects of PNM and lack of a system to ensure pull staff was provided with training prior to working with individuals who were at an increased PNM risk. Another issue noted was lack of training in an expeditious manner in response to a change in status. The Self-Assessment did not identify what activities were conducted for self-assessment, but rather included dated statements related to a variety of tasks since completed. Also, there was no mechanism to determine how the Facility had determined compliance or noncompliance with all items in this provision. The status statements did not reflect a strategic action plan, but overall, the actions appeared to be logical, and directed toward achieving compliance. RGSC provided detailed documentation of completion of tasks in an effort to reflect a plan to direct focus, work products, and effort by staff, but the two parts of the plan were not clearly linked. Action steps should be short-term, and stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps. Trend analysis should also be considered to present how the systems implemented have effected positive change with regard to the Settlement Agreement elements. The actions listed in the plan did not reflect a comprehensive strategic action plan developed to guide the department through the process of achieving substantial compliance across all provisions, but were generally related to content in previous reports or specific recommendations made by the Monitoring Team.
	Summary of Monitor's Assessment: **Provision O.1:** This provision was determined to be not in compliance. Areas of need include increasing the comprehensiveness in which the team responds to changes in status. **Provision O.2:** This provision was determined to be not in compliance. A risk process was in place; 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. Additionally, the PNMPs were inconsistent with recommendations made by the SLP during the MBSS.

	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. Another issue noted was the lack of enhanced training provided to the nursing staff. While the nurses had general knowledge of dysphagia, they lacked the knowledge to fully understand and implement strategies related to PNM. Included in this training should be enhanced PNM practices and individual specific training regarding PNM strategies. **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. Reliability of the completed monitoring forms were also called into question due to significant discrepancy between the high compliance rates noted in the forms and what was observed by the monitoring team. **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. Additionally there was not a process in place that represented a proactive approach to monitoring. **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 included assignment of a full time PNMT nurse who assisted with ensuring methods of care were shared with the accepting staff in the event of a hospitalization as well as post hospitalization assessment. Another positive was the increased frequency in which the PNMT met. As of this review, the PNMT was meeting on a weekly basis. Another positive was the need for continued enteral nutrition was integrated into the ISP.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional 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,	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 • Edith Partin RD PNM Team attendance records and meeting minutes from September 2011 to January 2012 documented weekly meetings with sporadic attendance by PNM Team standing members. • RN attended 20/21 (95%) meetings • MD attended 15/21 (71%) meetings • SLP attended 18/21 (85%) meetings • OTR attended 17/21 (80%) meetings • RD attended 16/21 (76%) 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 and lack of participation by psychology when the individual had behavioral challenges that may have had an impact on the issue discussed. Review of documentation of PNM clinical instruction submitted revealed four opportunities to participate in trainings relevant to increasing their knowledge of PNM. The three courses offered by DADS focused on Integration of Clinical Services, Dining Aspects, Evaluation and Treatment of Individuals with Developmental Disabilities and PNMT Core training. Per review of sign in sheets, participation of PNMT members were as follows: • PT attended 4/4(100%) offered trainings • RN attended 4/4 (100%) offered trainings • OT attended 3/4 (75%) offered trainings • SLP attended 4/4 (100%) offered trainings • RD attended 2/4 (50%) offered trainings • MD attended 0/4 (0%) offered trainings	Noncompliance

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	the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	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 had increased since the previous visit and at the time of the compliance visit was meeting weekly. New for this visit was development of a PNMT process (2/2/12). The Facility PNMT process defined the roles and responsibilities of the PNMT and the collaboration that was intended to occur with the Interdisciplinary Team (IDT). Included in this process was a defined criterion that stated what incidents must be referred to the PNMT and what may be referred to the PNMT. There was a section regarding trends and analysis but this section of the process was vague and still did not a clear QA component in which data relevant to physical and nutritional supports were 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 IDT or reviewed consistently by the IDT. 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 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	Individuals for sample #1 were chosen from the list of individuals who were diagnosed with a pneumonia and/or choking event since the previous compliance visit. The sample consisted of five individuals who accounted for 100% of the individuals who experienced pneumonia or choking event. Sample #2 consisted of 14 individuals who were chosen from a list provided by RGSC of 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 risk list accounting for 33% of individuals who were at an increased aspiration risk and 100% of those who were at a high risk of choking. Sample #3 consisted of 100% of the individuals (three) who received enteral nutrition. Sample #4 consisted of 30% of individuals (three) who experienced a change in their diet	Noncompliance

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	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.	texture since the previous compliance visit. Based on a review of 17 individuals' (sample #1, and #2) most recent OT/PT and SLP assessments, two of 17 Individuals (11%) 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. For example: • Individual #29's oral motor evaluation only stated that skills were adequate for intake. While the function of adaptive equipment was included in the assessments, three of 17 (17%) (Sample #1, and #2) assessments reviewed contained the link between a piece of equipment and the decline in function in which it was intended to address. For example: • Individual #97's OT/PT assessment stated that a plate-guard assisted with scooping but did not mention the etiology or decline that led to the need for the adaptive equipment. • Individuals #48'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. 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 #29'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 98's medication administration section stated "crush medication and place in applesauce" but there was no evidence of assessment determining this form of administration as being optimal. A concern was noted with the MBSS reports, as the diet texture classifications utilized in the MBSS were significantly different than the texture classifications utilized at RGSC. This variance in classification resulted in confusing reports in which the recommendations from the study were unclear. RGSC was aware of this issue and were working to resolve the concern. A comprehensive PNMT evaluation had been developed and approved by state office. The PNMT in its format appeared to be comprehensive in that it covered: • Risk factors	

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		• Medication side effects • Oral motor assessment • 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. Due to the lack of completed PNMT evaluations, this will need to be reviewed at the following compliance review. Based on a review of 17 (samples #1 and #2) records of individuals who experienced pneumonia or choking event and/or were noted by the Facility to be at an increased risk of aspiration and choking, six of 17 (35%) records reviewed accurately identified individuals who were at an increased risk of physical and/or nutritional decline. Examples of individuals not being appropriately identified include: • Individual #76 as per MBSS was diagnosed with severe oral and pharyngeal dysphagia but was listed as being at a low risk of aspiration and choking. MBSS stated there was reduced lingual strength, decreased coordination, decreased tongue base retraction, decreased epiglottic inversion and delayed laryngeal elevation. These findings do not represent a mild impairment. These issues paired with a pneumonia that occurred on 12/17/11 warrants a high risk rating. • Individual #97 as per MBSS was diagnosed with severe oral and pharyngeal dysphagia but was listed as being at a medium risk of aspiration and choking. • Individual #36 has no rotary movement, takes large bites, eats fast, and is known to grab non-recommended textures but was only listed as being at a medium risk of choking. • Individual #13 has moderate pharyngeal delay, regurgitates food, is on a modified diet and will seek non-recommended liquids when thirsty, yet was listed only as being at a medium risk of aspiration. • Individual #113 has moderate pharyngeal dysphagia, has decreased labial strength and range of motion, and is on a fluid consistency in which penetration was observed but was only listed as a medium risk of aspiration. Lack of critical clinical thinking and discussion was noted when the IDTs had to move	

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		beyond the guidelines. This lack of clinical judgment impacted the risk scores and increased the likelihood of inadequate supports being provided to the individual. One out of five (20%) individuals who were diagnosed with a PNM issue (sample #1) was assessed or comprehensively discussed by the PNMT or IDT. For example: • Individual #76 was diagnosed with pneumonia on 12/17/11 but there was no evidence of comprehensive assessment or review by the PNMT or IDT. PNMT minutes stated that there might be a need for a swallow study due to the fact that it may be aspiration. Once the study was completed, the PNMT had a brief statement stating to keep the individual on a regular diet. No further investigation was provided. • Morning medical team minutes 12/19/11 recommended a special staffing for both Individual #46 and #76 but there was no evidence that this occurred. • Individual #108 was diagnosed with pneumonia on 1/6/12 but there was no evidence of reassessment or discussion of the event by the IDT pr PNMT. Zero of three Individuals (0%) who had diet downgrades were discussed by the IDT. (Sample #4). For example: • Individuals #25, #97, and #121 all had their diets downgraded but there was no discussion or evidence of notification to the team. The Medical Team Meeting Notes serves as a notification and did provide evidence of investigation or team discussion surrounding the event. At most, it referenced the need of an additional IDT meeting and as stated, this did not consistently occur.	
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	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 as well as use of adaptive equipment. Based on a review of an identified sample of 18 individual records (Sample #1, #2, and #3), individuals were not provided with a comprehensive PNMP as evidenced by: • In five of 18 records reviewed (27%) comprehensive strategies for medication administration were included. • In zero of 18 records reviewed (0%) positioning of staff during medication administration and oral care was included. • In four of 18 records reviewed (22%) comprehensive strategies for oral hygiene were included.	Noncompliance

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	difficulties.	• In two of 18 records reviewed (11%) personal care instructions were included. • In ten of 18 records reviewed (55%) strategies focused on mealtime were specific and detailed. Examples of individuals who were not provided with a comprehensive PNMP included: • Individual #48'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 #29's oral care section did not contain information regarding the need to reduce water or thicken liquids during oral care. The individual was on thickened liquids. • Individuals #113 PNMP contained vague directions such as "cue to take small bites" or "cue to take liquids" but did not provide information on type of cues to provide or a descriptor of what constituted a "small" bite for that specific individual. Additionally, based on review of Medication Administration on La Paloma and El Paisano (16 individuals), individuals were not consistently provided with a comprehensive medication administration section of the PNMP. This was a pervasive issue. Information contained in the dining section that promoted safe intake was not transferred over to the medication administration section. The PNMP would contain information in the dining section regarding safe intake but this information was lacking in the medication administration section. For example: • Individual #51 medication section did not include information regarding the need to have multiple swallows with each sip. • Individual #29 requires a nosey cup but this was not included in the medication administration section. PNMPs were also noted to have become extremely cumbersome and not user friendly. Information that was not relevant to staff use often overshadowed the detailed information that was essential to safe PNM practices. Outcomes, Triggers and Risks not related to PNM were included resulting in the PNMP becoming a 5-6 page document. 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 PNMPs, lack of implementation (as stated above), and lack of inclusion of strategies recommended by the MBSS. Per review of 16 individuals' PNMPs, MBSS reports and dining plans (sample #8), which accounted for 100% of individuals who had received a MBSS during the months of September 2011 to January 2012, seven of 16 (43%) contained consistent	

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		information. For example: • Individual #85's dining plan stated to alternate liquids and solids while the PNMP stated to offer liquids throughout the meal • Individual #29 dining plan stated to use a "wonder-flo cup" while the PNMP did not include this piece of adaptive equipment. Additionally, the MBSS stated to alternate liquids and solids but this was not listed on the plans. Lack of consistency across plans results in an increased risk of harm due to confusion of staff and lack of a routine comprehensive approach to care. Based on a review of an identified sample of 17 individual records (Samples #1, and #2), PNMPs and dining plans were not formally developed with input from the IDT. In zero of 17 records reviewed (0%), PNMPs were clearly developed with input from the IDT with an emphasis on DCPs, medical/nursing staff, and behavioral staff (if appropriate). Per record review, there was evidence in the PSPs that portions of the PNMPs were included (i.e., diet texture) but this was not consistent and there was no evidence of discussion or input from other team members.	
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 IDT 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 it was not readily to staff. At no time during any of the observations was staff observed referring to the PNMPs. In most cases, pictures were available with the PNMPs. Pictures related to wheelchair and bed positioning, and the use of orthotics or braces were not consistently included as part of the PNMP or as part of any supplemental plan of care related to PNMP. This was; however, an area that was being addressed through the development of the new PNMPs. Three mealtime observations (1 breakfast, 1 lunches, and 1 dinner) 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. Examples in which staff did not implement interventions and recommendations outlined in the PNMP and/or dining plan include: • Individual #80 was observed taking large sips and hyper-extending his neck. • Individual #113 was eating at an unsafe rate and was not monitored for oral pocketing • Individual #4 was not provided cues to eat slowly, take small bites or alternate liquids and solids. • Individual #140 was not cued to slow down and was observed hyper-extending her neck.	Noncompliance

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		• Individual #66 was provided with full cups of liquid when the plan called for enough liquids for a single sip. • Individual #36 was observed eating Cheese Puffs when she was listed as being on a ground diet. When asked about the safety of this, it was reported that they melt in your mouth. The concern is that the puff is able to be swallowed whole and therefore causes a choking risk for someone on a ground diet. • Individual #72 was not prompted to take small bites and sips. • Individual #80 was taking large bites and not provided liquids throughout the meal. • Individual #19 was provided with sips greater than 10 ccs. Overall, there was limited 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 five direct support professionals (three on La Paloma and two on El Paisano): • In five of five (100%) interviews with staff, they were able to identify the location of PNMP and mealtime plan. • In two of five (40%) interviews with staff, they could describe individual-specific PNMP strategies. • In one of five (20%) interviews with staff, they could describe the schedule for implementation of PNMP strategies. • In two of five (40%) 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 competency-based training in how to implement the mealtime and	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 Missing from the training was: • Optimal alignment and support in seating systems and alternate positions	Noncompliance

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	positioning plans that they are responsible for implementing.	• Body mechanics The only evidence of skills-based or competency-based training was regarding PNMP, Communication, Hearing Aid Use 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 for Individuals #26, #97, and #121 (sample #4) 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. Another issue was that therapists were not fully aware as to who had been trained on changes in diet texture. Per report by the SLP, the nurses train the supervisors and the supervisors train the staff but once the training was completed, the information was never returned to the appropriate therapist, in this case, the SLP. It was also unclear as to whether the training of specific strategies were provided solely by clinicians or if those duties were passed along to professionals who lacked the training needed to fully teach the needed interventions. Another issue noted was the lack of enhanced training provided to the nursing staff. While the nurses had general knowledge of dysphagia, they lacked the knowledge to fully understand and implement strategies related to PNM. Included in this training should be enhanced PNM practices and individual specific training regarding PNM strategies.	
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. 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	Noncompliance

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		included: • Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, • Identification of monitors and their roles and responsibilities, • Revalidation and inter-rater reliability 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. • Monitoring schedule based upon level of risk. Per review of the PNMT minutes (September 2011 to January 2012), 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, 78 monitors were completed for 30 individuals utilizing the comprehensive monitoring from September 2011 to December 2011. A review of Facility monitoring list from September 2011 to December 2011 documented that staff were not being monitored in all aspects in which the individual was determined to be at increased risk. Monitoring continued to focus primarily on mealtimes. Per review: • 51 of 78 (65%) monitoring forms focused on oral intake (meals and snacks) • 2 of 78 (2%) monitoring forms focused on bathing • 6 of 78 (7%) monitoring forms focused on medication administration • 3 of 78 (3%) monitoring forms focused on oral care. • 7 of 78 (8%) monitoring forms focused on mobility. • 4 of 78 (5%) monitoring forms focused on lifting/transfers and orthotics • 5 of 78 (6%) monitoring forms focused on adaptive equipment 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. Another issue was that the monitoring forms contained a section labeled compliance and noncompliance. Compliance was achieved with a score of 80% or higher. The problem was that each question was weighted equally resulting in staff being allowed to not implement the PNMP and still have a score high enough to be rated as in compliance.	

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		The reliability of the completed monitoring forms is questioned due to the significant discrepancy between compliance noted by staff completing the forms and what was observed by the Monitoring Team. See Provision O.4 for additional information. An Aspiration Trigger Sheet was implemented but had only been so since 1/26/12. Per review, the trigger sheets were provided to individuals who were identified as being at a moderate or high risk. The development of this data sheet is a positive step forward in better being able to identify signs and symptoms. The issue with the existing Data sheet included: • Lack of individualized triggers • Lack of notification of all occurring triggers. For example, a trigger may not be documented or nurse notified if the trigger stopped occurring after repositioning. • Lack of consistent and detailed documentation surrounding the occurrence of triggers (e.g., activity in which trigger occurred, positioning of the individual) • Lack of consistent completion by staff (missing data points) • Trigger sheets contain information that was not relevant to the individuals (e.g., an individual who eats by mouth had a trigger that states to watch for formula in the mouth, which would be relevant only for people on enteral feeding). RGSC was aware of the lack of individualized triggers and how some triggers were not appropriate for the individual, but the concern was that staff continued to mark data points and, per interview, did not appear aware that the trigger was not relevant to the individual.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	Based on the review of 18 individual records (sample #1, #2, and #3), the PNM Team or IDT 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 individuals with the most complex physical and nutritional support needs. While PNMPs are reviewed at the annual ISP, there was not a system fully in place that clearly monitored the effectiveness of the plan by tracking clinical indicators for all individuals who were 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 consistent evidence that plans were reviewed by the PNMT or IDT as indicated by a change in	Noncompliance

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		status. For more information please see Provision O.2 The clinicians did not conduct routine, proactive review of the plans 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 three (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 (APEN). 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 IDT. This process had just begun at RGSC. There were three individuals listed as receiving enteral nutrition. The Monitoring Team requested enteral evaluations for individuals for all enterally fed (NPO) individuals. All individuals who were enterally fed (sample #3) received an APEN, but upon review, the APEN did provide much information in the way of investigation. It provided a list of current supports but did not facilitate reassessment or the development of new supports. For example, polypharmacy was included on the report but only focused continuing quarterly medication reviews rather than looking at each medication and its potential impact on swallowing (for example., Seroquel and Haldol). Additionally, it contained many areas that were not related to nor had the potential to be related to the aspiration event. An example is Individual #97. This individual's APEN included information on	Noncompliance

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		Falls and Challenging Behaviors. Based on the sample of three individuals (sample #3), all individuals had received the interdisciplinary enteral nutrition assessment provided by the State. The three individuals had received a Habilitation Therapy assessment but content lacked analysis regarding potential pathways to intake. While three of three (100%) assessments included why the tube was medically necessary, zero out of three 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. The need for continued enteral nutrition was integrated into the ISP. Based on a review of three individuals' ISPs, three of three individuals who received enteral nutrition, the individual's ISP 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. 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)
2. 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 is to do if these triggers are observed. (Provision O.7)
3. 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)
4. 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)
5. 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)

6. All individuals who are determined to be at an increased risk should only be provided assistance from staff who have received competency based training specific to that individual. (Provision O.7)
7. 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, adaptive equipment and identification of intake strategies. (Provision O.3)
8. The monitoring form should be reviewed and revised to improve accuracy of compliance data. (Provision O.6)
9. PNMP format should be revised so that it is less cumbersome and more user friendly to staff. (Provision O.3)
10. All nursing staff should be provided with enhanced dysphagia training (i.e., the state office training). (Provision O.5)

The following are offered as additional suggestions to the Facility:

1. Due to the high percentage of behavioral issues associated with PNM at RGSC, a psychologist should be named as a permanent member of the PNMT. (Provision O.1)
2. The designation of staff whose responsibility is to ensure dining plans are implemented correctly would greatly assist RGSC in reducing implementation issues. This could be the development of PNM coordinators or utilization of existing senior staff. (Provision O.4)

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. Record Reviews: f. Sample 1: Individuals #29, #46, #76, #97 and #108 g. Sample 2: Individuals #29, #36, #47, #48, #57, #79, #82, #98, #108, #113, #115, #121, #143, and #150 h. Sample 5: Individuals #36, #115, and #140 2. RGSC OT/PT Standard Operating Procedures MR700 06 (January 2010) 3. Current Lists of people: a. Who use wheelchair as primary mobility; b. With transport wheelchairs; c. With other ambulation assistive devices, including the name of the device; d. With orthotics and/or braces; e. Who have had a decubitus/pressure ulcer during the past year, including name of individual, date of onset, stage, location, and date of resolution. 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. 4. OT/PT assessments template 5. 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 6. List of individuals receiving direct OT and/or PT services and focus of intervention **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. Marcy Valdez RN 6. Lorraine Hinrichs 7. Five direct care staff (3 La Paloma and 2 El Paisano) **Meeting Attended/Observations:** 1. PNMT meeting 2/28/12 2. La Paloma lunch and dinner 3. El Paisano lunch and dinner 4. Las Paloma and El Paisano transition times 5. Medication Administration 2/28/12 La Paloma and El Paisano
	Facility Self-Assessment: RGSC Self-Assessment, updated 2/13/12, provided comments/status for Sections P.1 through P.4 of the Settlement Agreement. The Facility indicated it was not in compliance with Provisions P.1 through P.4.

	This was consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. The Self-Assessment did not identify what activities were conducted for self-assessment, but rather included dated statements related to a variety of tasks since completed. A self assessment monitoring tool was completed but there was no clear mechanism to determine how the Facility had determined compliance or noncompliance with all items in this provision. RGSC provided detailed documentation of completion of tasks in an effort to reflect a plan to direct focus, work products, and effort by staff, but the two parts of the plan were not clearly linked. Trend analysis should also be considered to present how the systems implemented have effected positive change with regard to the Settlement Agreement elements. An example of utilizing data, would be the tracking of the occurrence of falls and then correlating that decrease in interventions provided by RGSC> The actions listed in the plan did reflect a plan developed to guide the department through the process of achieving substantial compliance across all provisions, but at times were vague and contained more of a general statement thus lacking the detail needed to gain a clear understanding of the pathway to compliance. Action steps were not consistently stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps Although a number of concerns continued to exist with the Facility's self assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance.
	Summary of Monitor's Assessment: **Provision P.1:** This provision was determined to be not in compliance. RGSC had one PT, a part time PT and two part time OTs (one will be leaving 3/30/12). 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 was 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 was a sensory room, calming room as well as the development of 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 issue with the gym is that is has been 6 months since the last compliance visit and the gym still was not being utilized. Per interview with Habilitation Therapies, the development of a sensory room was also being looked at for the homes but this had not occurred as of this review.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	The Facility did not provide an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience. The Facility hired an additional contract Physical Therapist who will provide an additional 13 hours per week. Although the additional PT will help RGSC, due to the responsibilities of the full time PT (PNM lead, Habilitation Therapy Director), it was still not considered to be an adequate number of Physical Therapist to meet the needs of the individuals. RGSC has also hired an additional OT in addition to the existing OT on staff; however, the existing OT will be leaving at the end of March 2012; therefore, RGSC will be left again with one OT providing 16 hours per week. Like Physical Therapy, this is not sufficient to meet the needs of the individuals. 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	Noncompliance

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		mobility, as well as fine motor skills and independence (for example, of 10 ISPs reviewed for Section U, three individuals were identified as having gait problems, and the supports needed for community movement included a one-level home for seven individuals). 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 needs beyond those related to the PNMP. Per observation, there was a noticeable increase in the amount of lift vests utilized to assist with gait issues but lack of therapy to address the gait issues outside of adaptive supports. Based on this review, a very limited number of individuals were provided with OT or PT services beyond the PNMP (only eight individuals were receiving direct PT therapy and zero individuals were receiving direct OT services). All newly admitted individuals (sample #7) had received an OT/PT assessment within 30 days of admission. The assessments submitted were completed by both OT and PT. Sample #5 consisted of 100% of the individuals with greater than 4 falls over the past 4 months. Assessments indicated whether or not the individual required OT/PT supports and services for 19 of 19 (100%) (Sample #1, #2 and #5) records reviewed but the problem with the recommendations were that the recommendations were limited to stating "Follow the PNMP" and consult if needed and did not provide any additional guidance or strategies to address the decline in skill. The OT/PT assessment had sections that were meant to address 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 as well as comprehensive assessment intended to identify changes in status and provide full investigation into the etiology of the decline or treated issue. There remained a lack of objective measurable data as well as explanation of how these deficits are functionally affecting the individual. Other specific issues noted included: • Updates did not consistently make reference to a previous comprehensive assessment. Though the outline stated that only new or changed information would be included in the update, this was not stated in the update itself. Combined with no reference to a previous assessment, the update appeared incomplete. It would not be known if the clinicians omitted information or that	

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		an area was unchanged and, therefore, was not addressed in the update. • There were very limited skill acquisition programs; in the case that these were in place, the assessments for those individuals did not provide any discussion of the progress achieved as a result of the intervention. The assessments did not consistently establish a baseline from which to measure change or progress through intervention. • In many cases, analysis statements were scattered throughout the report and it was difficult to discern the clinical reasoning used by the clinicians to guide the development of an intervention plan(s) and recommendations. Medical issues and health risk indicators were not consistently included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions. Nineteen of the 19 (100%) assessments (Sample #1, #2, and #5) reviewed contained medical issues and health risk indicators but Zero of 19 (0%) provided 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' #36 and #115'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 19 (Sample #1, #2, and #3) OT/PT assessments, 100% included signatures and date of both OT and PT. Review of individuals with changes in status (sample #5) did not provide evidence of assessment or review as indicated by a change in the individual's status or as dictated by monitoring results. • Individuals #36 experienced multiple falls over the period ranging from October 2011 to December 2011 but there was no evidence of assessment or review by the PT, PNMT or PST. • Individual #115 had multiple falls over the period ranging from October 2011 to December 2011 but there was no evidence of PT reassessment. 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 IDT review of the incident and PT assessment. Based on review of sample #5 this occurred zero of three opportunities (0%). As stated previously, there was a noticeable increase in the amount of lift vests utilized to assist with gait issues but lack of therapy to address the gait issues outside of	

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		adaptive supports Individual #80 who was scheduled to be discharged was of particular concern to the monitoring team. Individual #80 was diagnosed with SIB with Head Banging, History of Tonic Clonic Seizure, Autism, Profound Mental Retardation, and Cervical Stenosis. Documents reviewed included: • 5/17/10 OT/PT assessment • 4/22/11 OT/PT assessment • 11/16/10 consult • 12/31/11 consult Review of the records indicated significant decline over the past 12-18 months. Assessment on 5/17/10 and consult on 11/16/10 indicated no ataxia or scissoring of gait and normal balance. Assessment conducted on 4/22/11 stated that his balance was able to be maintained for no more than a minute and the consult dated 12/31/11 stated that he could ambulate up to 20 ft before falling. Per observation, Individual #80 was unable to maintain balance without assistance and was unable to ambulate safely at all without 1:1 assistance. The concern regarding this matter revolves around two issues. The first issue was that there was not a comprehensive PT assessment conducted recently that accurately reflects his current status and provides clear instructions for staff to follow to ensure safety. The second issue revolves around ensuring supports are in place in prior to discharge. Documentation in the record indicated that a 1:1 would only be able to be continued for up to 6 months. This will not be sufficient unless there is drastic improvement in the overall functioning. Due to the cervical stenosis, the risk of serious injury should the individual fall is extremely high. It is the concern of the Monitoring Team that lack of comprehensive assessment and planning prior to discharge will result in the individual being placed at unnecessary risk.	
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	Based on review of comprehensive OT/PT assessments or updates, PNMPs and associated instructional plans, Activity Plans, Treatment plans and clinician progress notes for 18 individuals (sample #1, #2, and #7) if 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 administrations were not based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies. For example:	Noncompliance

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	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.	• Individual #121'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 been implemented but was not provided for all individuals in need of such an assessment. The assessment focused solely on O2 sats, Blood Pressure, Heart rate, and Lung Sounds. Missing from the assessments were indicators of comfort and or ability to sustain the recommended position. Additionally, the assessments were mostly incomplete and did not include all potential methods of positioning (i.e. varying degrees of elevation or the use of sidelying). Based on reviews of PNMPs for 19 individuals (sample #1, #2, and #3), equipment was specified for 19 of 19 (100%) plans reviewed. Within 30 days of the annual ISP planning meeting, or sooner as required for health or safety, a plan was developed as part of the ISP but was not consistently reviewed by the IDT. Plans were generally limited to the PNMP that was reviewed at the time of the annual ISP and were updated as needed due to a change in status. The main issue was that there was no evidence that the majority of plans were reviewed by the IDT 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 Special Program Objectives (SPOs) addressed areas related to positioning, transfers, handling, and mobility, but interventions were limited when related to promoting independence and skill acquisition; based on review of 19 individuals (Sample #1, #2, and #3) interventions did not focus on skills acquisition or independence. PT intervention was generally designed to address gait and ambulation. OT intervention was limited only to assessments. For those individuals receiving direct services, justification for continued therapy or discharge was well documented in the progress notes. Programs and interventions for other skill acquisitions 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.	

#	Provision	Assessment of Status	Compliance
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 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 five of five (100%) 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. An example of direct care professionals who were not able to describe the rationale for OT/PT interventions and recommendations: • DCP was not able to describe rationale for maintaining appropriate elevation.	Noncompliance
P4	Commencing within six months of	The Facility had not yet developed a system to monitor and address all the	Noncompliance

#	Provision	Assessment of Status	Compliance
	the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	requirements of this provision. Per review of OT/PT monitors, a system did not exist that was designed to routinely evaluate fit and function of all adaptive equipment/assistive technology outside of the annual updates. Availability and condition were monitored; however, there was not a clear system as evidenced by inconsistent frequency of completed monitoring forms. For example, at times the monitoring form was three days apart and at other times was provided as much as 30 days apart. A policy did not exist that clearly defines the details of the monitoring system including frequency, implementation and acquisition of data. 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. 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, Activities of Daily Living (ADL) 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. There is a significant need to develop programs to address increasing or expanding functional skills. Formal programming is indicated for a number of individuals. OT/PT staff should also model ways to promote skill acquisition and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs. Therapists should push forward with the development of more collaborative skill acquisition plans and modeling with groups to enhance the day programs and activities occurring in the homes. A program of this nature could be especially effective if implemented with the SLPs and/or psychology. (Provision P.2)
3. Review the existing OT/PT assessment format to address summary/analysis. As currently written, these were not consistently sufficient to establish the rationale for the recommendations. It is recommended that a more concentrated analysis of objective data be implemented rather than having it scattered throughout the report to reduce redundancy and making it a more meaningful and user friendly document. The development of a framework that included more specific guidelines for therapists in their treatment of the analysis of findings and justification for supports and interventions in the PNM clinic and the written reports would be useful, particularly with the addition of new therapy clinicians. The analysis of findings should cross all systems or clinical areas and should formulate the foundation or rationale for why specific aspects of the PNMP as well as other supports, services and interventions were indicated. (Provision P.1)
4. Clarify what constitutes a valid comprehensive assessment and subsequent updates. Ensure that updates reference a comprehensive assessment. (Provision P.1)
5. Include oral hygiene status in OT/PT assessments, not only positioning. Consider strategies to address sensory issues that may negatively impact the effectiveness of oral hygiene care. (Provision P.1)
6. 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)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-Assessment and Action Plan 2/13/12 2. RGSC Section Q Presentation Book 3. Audit tool for dental quality assurance for direct care staff, January 2012 4. Sign-in sheet for dental hygienist hours on duty 5. Training roster for staff trained on suction toothbrushing 6. Pre-medication for medical and dental procedures, November 2004 **People Interviewed:** 4. Yolanda Gonzalez, CNE and Lorraine Hinrichs, ICF-DD Program Director **Meeting Attended/Observations:** None
	Facility Self-Assessment: The Facility Self-Assessment reports that "based on the findings from this self-assessment, this provision is in substantial compliance (for Provision Q1) because a score of no data on dental emergencies or effectiveness of policy. Also pending dental data base". The Self-Assessment indicated that as of 12/2011, 98% of Individuals were up to date with regards to their dental appointments, and 100% of those not completed were rescheduled. The Monitoring Team disagrees with the Facility's Self-Assessment for Provision Q1, and determined the Facility to be noncompliant, based on the fact that the appropriateness and quality of dental services could not be assessed, and because oral hygiene efforts at the living area remain less then satisfactory. The Facility's Action plan for Provision Q1 outlines many important issues that are required for compliance; however, many of the action steps are simply items that were completed. The action plan must be a comprehensive, and dynamic process that delineates the major pathways required for ensuring that provision is satisfied. The Facility reports noncompliance with provision Q2, and the Monitoring Team concurs with this assessment.
	Summary of Monitor's Assessment: Provision Q1: The Facility lacks dedicated resources to oversee and manage dental services at the Facility. There were no policies or practices that enable an understanding of the necessary supports and services required to ensure adequate oral health care for individuals at the Facility. The Facility could not effectively convey what dental action plans were necessary for individuals at the Facility. Although the Facility has a triage mechanism for dental emergencies, the Facility does not have a process to track dental emergencies, and were unable to provide a list of those who experienced a dental emergency during the previous six months. Although the contract hygienist continues to work diligently on enhancing oral hygiene efforts at the living area, staff must enhance their ability to administer oral hygiene, and ensure individuals are provided necessary oral hygiene at their living area. The Facility does not have a mechanism that enables the routine assessment of oral suction toothbrushing needs, and at the time of this

	review, only one individual was administered a suction toothbrush. Dental records are not being affectively placed into the Integrated Progress Notes. For these reasons, the Monitoring Team has determined that the Facility remains not in compliance with Provision Q1. It is essential that the Facility assign dedicated staff to manage dental services at the Facility. Provision Q.2: The Monitoring Team determined that the Facility remains noncompliant with Provision Q2, because it does not have effective policies, procedures, and practices to ensure that appropriate dental desensitization and/or other methods to reduce the need for pharmacotherapy forms of sedation during dental treatment are implemented; lack of meaningfully integrating dental services into the IDT process and representing dental issues in the ISP; not maintaining a dental record and integrating dental progress notes into dental notes into the IPN; and not having dental summaries.

#	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.	To assess provision for Q1, the Monitoring Team met with Yolanda Gonzalez CNE, who was assigned the Settlement Agreement coordinator for Provision Q. During the meeting, the Monitoring Team was informed that the Facility did not have a specific staff person assigned to oversee dental services at the Facility, and for the most part, the Nursing Department was responsible for maintaining the dental schedule, and a recently hired contract dental hygienist was responsible for implementing oral hygiene efforts at the living area. Otherwise, individuals were sent to local dentists for their routine and restorative dental treatment. There was no one assigned staff person to perform quality assurance reviews of dental service, or responsible to develop, update, and implement dental procedures. With the exception of a spreadsheet, and a process that enables the scheduling of dental appointments, the Facility could not provide the Monitoring Team with meaningful information regarding dental services such providing the Monitoring Team with an active list of people who require anesthesia, oral pre-treatment sedation, or behavior desensitization. <u>Dental Emergency</u> The Monitoring Team requested the Facility's policy for dental emergencies, and was informed that one was not available. The Monitoring Team also requested a list of individuals who experienced dental emergencies, and their associated dental records, and physician assessment of the dental emergency; however, the Facility could not provide that information. The Monitoring Team was informed that the Facility did not have a process to track dental emergencies. <u>Routine Dental Care</u> The Facility was unable to provide the Monitoring Team with specific information as to	Noncompliance

#	Provision	Assessment of Status	Compliance
		which individuals were actually current with their oral health care needs. They maintained a list of individuals who have been seen by the dentist, but were unable to inform the Monitoring Team as to which individuals were current with their dental treatments, or which individuals had outstanding dental issues. Dental Scheduling The Facility continued to maintain a spreadsheet for scheduling dental appointments. Nursing services provided the scheduling services for the Facility. As soon as someone returns from the dentist, the return visit date is entered into the spreadsheet. The Living area is notified of pending dental appointments timely <u>Oral Hygiene</u> The Facility contracted with an independent dental hygienist to provide training to staff on the administration of oral hygiene. In addition, the dental hygienist occasionally provided oral hygiene support to some individuals at the Facility. The dental hygienist provided quality assurance assessments (QA) of direct care staffs ability to administer oral hygiene. The Monitoring Team was provided with the result of the last QA session, which was conducted in January, 2012, at which a total of 42 direct care staff were assessed. Thirty-two out of the 42 (76%) demonstrated proficiency when administering oral hygiene. During morning medical rounds, participants raised the issue of the need to enhance dental services and hygiene efforts, and stated that the condition oral health was unacceptable, and that dental services needs to be enhanced. Of the oral health condition of the individuals observed by the Monitoring Team (Individuals #31, #101, #141, #21, #134, #139, #5,), three out of seven (45%), demonstrated their oral cavity free from gross debris. <u>Suction Toothbrushing</u> The dental hygienist had provided an in-service to direct care staff on suction toothbrushing. The Monitoring Team was provided a list of staff who were provided suction toothbrushing training that demonstrated a total of 30 staff were trained on suction toothbrushing. The Facility reported having one individual who currently was administered a suction toothbrush, but reports not having a process to determine who has, and has not been evaluated for the need of suction toothbrushing. Conclusion The Facility lacked dedicated resources to oversee and manage dental services at the Facility. There were no policies or practices that enable an understanding of the necessary supports and services required to ensure adequate oral health care for individuals at the Facility. The Facility could not effectively convey what dental action plans were necessary for individuals at the Facility. Although the Facility had a triage mechanism for dental emergencies, the Facility did not have a process to track dental	

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		emergencies, and were unable to provide a list of those who experienced a dental emergency during the previous six months. Although the contract hygienist continued to work diligently on enhancing oral hygiene efforts at the living area, staff must enhance their ability to administer oral hygiene and ensure individuals are provided necessary oral hygiene at their living area. The Facility did not have a mechanism that enables the routine assessment of oral suction toothbrushing needs, and at the time of this review, only one individual was administered a suction toothbrush. Dental records were not being effectively placed into the Integrated Progress notes. For these reasons, the Monitoring Team has determined that the Facility remains not in compliance with Provision Q1. It is essential that the Facility assign dedicated staff to manage dental services at the Facility.	
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.	<u>Pre-Treatment Oral Sedation</u> While assessing the Facilities use of pre-treatment sedation for dental services, the Monitoring Team was informed that there was no current process that effectively identifies individuals who require pre-treatment sedation, and that just prior to each and every dental appointment, the primary care physician determines what, if any, medication and dose should be administered. There was no dental service at the Facility that monitors the use of pre-treatment sedation, except for pharmacy, when reporting on Stat medications to the Pharmacy and Therapeutic Committee. <u>Intravenous Sedation</u> The Facility does not provide i.v. sedation to individuals for dental services. Individuals are administered either oral pre-treatment sedation or general anesthesia. <u>General Anesthesia</u> The Facility reported that it does send individuals for general anesthesia, but that they have no way of effectively identifying or tracking individuals who may benefit by general anesthesia, and could not provide the Monitoring Team with a comprehensive list of individuals who require general anesthesia for dental services. <u>Integration of Dental Services into the IPN and PSP</u> During its meeting with dental services, the Monitoring Team was informed that the Facility did not have an effective mechanism to integrate dental progress notes into the IPN, and did not routinely integrate dental issues into the ISP. The Monitoring Team asked for copies of dental progress notes, current annual dental assessment, and copy of corresponding PSP reports for Individuals #108, #5, #12, #11, and 139; however, the Facility could not produce the information requested. <u>Interventions to Minimize the Use of Sedating Medications and/or Restraints</u>	Noncompliance

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		The Monitoring Team was informed that dental desensitization is being provided though a combination of efforts with the dental hygienist and the psychology department; however, this process could not be well described during the Monitoring Team's meeting with dental services, other then that psychology services, in collaboration with the dental hygienist had started to provide dental rehearsals, during which time individuals are placed in a dental chair, to help accustom them to the real life scenario of a dental office. Dental Services could not provide written documentation of this process, nor were they able to provide a specific list of individuals who required such intervention or progress made by individuals who had undergone dental rehearsals. The Monitoring Team requested a copy of the Facility's dental desensitization policy and procedure, but the Facility did not have such policy; the Facility provided the Monitoring Team with the Facility's procedure for "Premedication for medical and dental procedures", dated November 2004. Conclusion: The Monitoring Team determined that the Facility remains noncompliant with Provision Q2, because it does not have effective policies, procedures, and practices to ensure that appropriate dental desensitization and, or other methods to reduce the need for pharmacotherapy forms of sedation during dental treatment are implemented; lack of meaningfully integrating dental services into the IDT process and representing dental issues in the ISP; not maintaining a dental record and integrating dental progress notes into dental notes into the IPN; and not having dental summaries.	

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

1. Provide adequate resources to manage dental services at the Facility. (Provision Q1)
2. Ensure that all dental services are tracked, and that a dental action plan is in place for each individual. (Provision Q1)
3. Ensure that there is a process to track dental emergencies. (Provision Q1)
4. Develop and implement a mechanism that routinely ensures that all individuals who require suction toothbrushing have been assessed and that all individuals who require suction toothbrushing receive it. (Provision Q1)
5. Enhance oral hygiene efforts at the living area. (Provision Q1)
6. Develop a QA process that helps to ensure that individuals are being provided necessary dental services, and supports needed to ensure good oral health care. (Provision Q2)
7. Ensure that the Facility maintains a dental record for all individuals, and that dental notes are assimilated in the IPN, and that all necessary dental supports, services and description of dental issues are clearly defined in the ISP. (Provision Q2)
8. Ensure that specific restraints that might be necessary to provide dental services, such as behavioral intervention, pre-treatment sedation, use of intravenous sedation and general anesthesia, are assessed for each individual through the ISP process. Provision Q2)
9. Ensure that the Facility develops a program to minimize use of sedation medications and/or restraints that includes a process to help ensure that the least restrictive therapies that might be effective are employed for dental procedures. (Provision Q2)

10. Ensure that each individual is provided a comprehensive annual dental summary. (Provision Q2)

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 2/13/12 2. Record reviews: i. Sample 1: Individuals #29, #46, #76, #97 and #108 j. Sample 2: Individuals #29, #36, #47, #48, #57, #79, #82, #98, #108, #113, #115, #121, #143, and #150 k. Sample 6: Individuals #1, #74, #93, and #118 l. Sample 7: Individuals #46 and #127 3. Ten communication programs selected by RGSC 4. RGSC Communication Services Standard Operating Procedure MR700 07 (1/2010) 5. A list of people with Alternative and Augmentative Communication (AAC) devices 6. AAC evaluation and Speech Language assessment template 7. Monitoring tools template for ACC and SLP programs 8. List of individuals receiving direct speech services, and focus of intervention 9. Behavior Support Committee (BSC) minutes from September 2011 to December 2011 **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. Five direct care staff (3 La Paloma and 2 El Paisano) **Meeting Attended/Observations:** 1. PNMT meeting 2/28/12 2. La Paloma lunch and dinner 3. El Paisano lunch and dinner 4. Las Paloma and El Paisano transition times 5. Vocational education Classes
	Facility Self-Assessment: RGSC Self-Assessment, updated 2/13/12, provided comments/status for Provisions R.1 through R.4 of the Settlement Agreement. The Facility indicated it was not in compliance with Provisions R.1 through R.4. This was consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. The Self-Assessment did not identify what activities were conducted for self-assessment, but rather included dated statements related to a variety of tasks since completed. A self-assessment monitoring tool was completed but there was no clear mechanism to determine how the Facility had determined compliance or noncompliance with all items in this provision. RGSC provided detailed documentation of completion of tasks in an effort to reflect a plan to direct focus, work products, and effort by staff, but the two parts of the plan were not clearly linked. Action steps

	were not short term and did not provide measurable terms with timelines and evidence required to demonstrate completion of all interim steps. Trend analysis should also be considered to present how the systems implemented have effected positive change with regard to the Settlement Agreement elements. An example of this would be providing data regarding improved oral care reports resulting form inclusion of oral care on the PNMP. Action steps were at times vague and presented as more of a statement than a measurable objective. An example would be "Will train staff on how to use AAC." This action step does not provide information regarding how this step will be accomplished as well as a short term completion date.. Although a number of concerns continued to exist with the Facility's self assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance.
	Summary of Monitor's Assessment: **Provision R.1:** This provision was determined to be not in compliance. Although an additional SLP had been hired, evidence gathered through the review indicated lack of participation in all facets of care (i.e., monitoring, and development of goals). **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. Additionally, others aspects within the scope of the SLP's practice were largely not addressed. This included the assessment of cognition (i.e., prospective memory) and the individual's ability to remain on task through activities. All individuals admitted since the last compliance visit received a communication assessment within 30 days of admission. **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 ISP. There were many positives noted within this Section. The number of shared devices had significantly increased across campus thus allowing greater access to said devices; however, it was unclear how functional many of the devices were due to overall lack of staff knowledge and utilization. Another positive was improved evidence of strategies or translation of nonverbal skills (i.e., communication dictionary) to assist staff with methods to increase communication; however, these strategies were not integrated into the overall plan of care.

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	The Facility had hired an additional SLP since the last compliance visit. This brings the total number of Speech Therapists to two which based upon census should be sufficient in meeting the needs of the individuals; however, the impact of an additional therapist had not been observed at the level of care.
		
		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
		  • ISP 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)
		• 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 IDT 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 #6 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.
		
		Three of 21 records (14%) (Sample #1, #2 and #6) reviewed indicated individuals with identified language difficulties were receiving active Speech Treatment or participating
			Noncompliance

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		in a Speech program. Examples of individuals with identified speech or language difficulties not receiving services: • Individual #48 had limited speech capabilities but there was no program to address the identified issues. • Individual #36 had a decreased ability to follow assigned tasks but there was no Specific Program Objective (SPO) or Specific Service Objective (SSO) to address this area. • Individual #98 had a communication book but there was no goal to address the learning of skills needed to utilize the book. Per review, only ten individuals at RGSC had a communication program. This accounts for only 14% of the population of RGSC and was not sufficient in meeting the needs of the individuals living at RGSC. Communication programs were limited at best for those who did not have a communication device.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	The communication assessments for samples #1 and #2 were neither detailed nor comprehensive enough to allow for the identification and potential expansion of communication skills. • In four of 17 (23%) records reviewed the assessment comprehensively addressed verbal and nonverbal Skills. • In two of 17 (11%) records reviewed the assessment comprehensively addressed expansion of current abilities. • In two of 17 (11%) records reviewed the assessment comprehensively addressed development of new skills. • In 17 of 17 (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 often due to lack of available trial AAC devices. For example: • For all individuals in the sample, the primary exposure to AAC was one or two button switches and picture cards. • Individual #97's assessment stated that he follows simple commands but provided no information regarding what the commands consisted of. • Individual #46's assessment only focused on communication and did not address memory or other areas related to cognition. For persons receiving behavioral supports or interventions, the Facility did not have a	Noncompliance

#	Provision	Assessment of Status	Compliance
		process designed to identify who would benefit from AAC or communication assistance. Per review of BSC minutes from September 2011 through December 2012, an SLP did not attend the meetings nor was there a clear process in place to ensure information was relayed for communication assessment or development of strategies. An example was Individual #140's replacement behavior focused on improving expressive language; however, there was no communication program developed.. Assessments did not address methods to maintain or enhance areas outside of basic communication although many individuals would benefit from the use of devices to assist with activity completion or the transition of activities. Examples of areas to address included prospective memory and cognition. All individuals admitted since the last compliance visit received a communication assessment within 30 days of admission. Since the previous review, there were two individuals admitted to RGSC. Records for these individuals were requested (Sample #7), Two of two individuals (100%) received a Speech Language evaluation within 30 days of admission. The admission evaluations were signed and dated by the Speech Language Pathologist.	
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. Rationales and descriptions of interventions regarding use and benefit from AAC were not clearly integrated into the ISP. Two of the 17 records (Sample #1 and #2) reviewed (11%) had a clear rationale and description of communication interventions integrated into the ISP. Examples of ISPs in which communication was not adequately integrated included: o Individual #76's ISP only mentioned that the individual was verbal and did not integrate strategies into the ISP. o Individual #82's ISP only commented on swallow status and included no information regarding communication. ISPs 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 improved evidence of strategies or translation of nonverbal skills (i.e., communication dictionary) to assist staff with methods to increase communication; however, these strategies were not integrated into the overall plan of care.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The ISPs 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: • Two of the 17 records (sample#1 and #2) reviewed (11%) clearly identified how the individual communicates with others and interacts with his surroundings. Communication information was not integrated into the daily schedule. For example: o Individual #48's assessment stated that he benefits from routines, responds when choices are provided and staff should utilize the shared devices; however, the use of the devices was not integrated into any SSOs or SPOs. General AAC devices were readily available in all common areas. Two of two (100%) homes had general AAC devices present in the Common areas. These devices consisted of a combination of voice activated communication boards and picture communication boards. Vocational Rehabilitation also had shared devices. This represented a significant increase in the number of shared devices. 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 and homes, there were 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, dining, bathroom) in which the use would have been beneficial and appropriate. Additionally, the picture boards were not functional as many individuals were not able at a communicative level that would allow for the training or benefit of such devices. Therefore, more assessment is needed to identify methods of communication that will provide a benefit to the individuals as well as staff. Another issue was that per interview with five staff, zero of five staff were able to identify the type of shared device (voice activated or picture board) most appropriate for their assigned individuals to utilize. Communication strategies/devices were not implemented and used. Three observations demonstrated that staff did not implement interventions and recommendations outlined in the Communication Assessment. Examples of individuals where staff did not	

#	Provision	Assessment of Status	Compliance
		implement a communication program as written included: • Individual #36 was not observed using shared devices. • Individuals #74 and #118 were not observed using their communication books. NEO staff training in the area of communication was largely lecture with limited opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	RGSC reported that a "Speech and Hearing Equipment Form" had been completed. There was evidence that RGSC conducted monitors that focused on the presence and working condition of AAC devices; however this process was not formalized in a policy that detailed the frequency in which the devices would be monitored. The monitoring forms reviewed did not focus on effectiveness of the devices due to the majority of devices being shared devices without a formal communication program paired with their usage. Data that was collected for individuals' devices through a formal communication program were not reviewed by the SLP on a consistent basis to ensure effectiveness and appropriateness of the devices. There was no evidence that effectiveness of each individual's AAC system was monitored by the SLPs beyond the assessment updates. See Provision R.3 for additional information.	Noncompliance

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

1. An increased presence and utilization of communication devices has occurred at RGSC; however, in most cases the picture boards were not functional as many individuals were not able at a communicative level that would allow for the training or benefit of such devices. Therefore, more assessment is needed to identify methods of communication that will provide a benefit to the individuals as well as staff. (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. There is an urgent need to develop programs to address increasing or expanding language skills, ability to make requests and choices, and other basic communication skills. Formal programming is indicated for a number of individuals. Speech staff should also model more informal ways to promote interaction and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs. (Provision R.2)
4. Communication assessments should be comprehensive and provide measurable data regarding the individuals' speech capabilities. Assessments

should include information on verbal skills, nonverbal skills, expressive and receptive language, AAC investigation, methods to improve existing language as well as methods to develop new language. Other areas that should be addressed include prospective memory and task completion. Clear direction and detail should be included in all sections. (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 monitors the equipment's use and ensures AAC equipment remains functional and relevant. (Provision R.4)
7. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the ISPs and in the PNMPs. Provision R.3)
8. Expand NEO training to include more opportunities for staff participation and return demonstration. (Provision R.3)

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 Self-Assessment and Action Plans 2. RGSC January 2012 Presentation notes 3. RGSC Section S Evidence Book 4. Documents that were reviewed included the annual ISP, ISP 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 Self-Assessment and Action Plans and included the following individuals: Individual #1, #4, #5, #11, #12, #19, #21, #27, #31, #33, #40, #46, #47, #48, #51, #55, #60, #60, #61, #62, #63, #66, #67, #69, #74, #75, #76, #77, #80, #82, #84, #87, #88, #91, #94, #96, #97, #98, #115, #118, #127, #134, #139, #140, #141, and #149 **People Interviewed:** 1. Lorraine Hinrichs – Program Director 2. Janie Villa – QDDP Coordinator 3. All QDDPs 4. Vanessa Villarreal, M.Ed. – Interim Psychology Director 5. Samantha Salinas, MSW – Contract Associate Psychologist 6. Alonzo Andrews, M.A., BCBA – Contract Psychologist 7. Direct Care Professionals: Approximately 15 staff members in residences, classrooms and vocational settings **Meeting Attended/Observations:** 1. Quarterly ISP Review Meeting – 2/27/2012 2. Human Rights Committee Meeting – 3/1/2012 3. Observations were conducted in all residences, classrooms, vocational settings, and leisure areas on 2/28/2012 and 2/29/2012.
	Facility Self-Assessment: At the time of the site visit, RGSC reported that no Provision was in substantial compliance with the SA. The Monitoring Team was in agreement with the Facility. The Facility provided two documents intended to present the status of current efforts to comply with the Settlement Agreement. The first was a Self-Assessment reflecting measures of progress. The second was the Action Plan that outlined the steps the Facility had identified as critical to satisfying the Settlement Agreement. At RGSC, two issues stood out in the review of the Self-Assessment and Action Plan The first was that the Facility was able to provide very little data regarding many of the Provisions of Section S of the

	Settlement Agreement. In some cases, the Facility indicated that data were missing because no monitoring had been initiated. In other cases, however, there was no explanation as to why data were not available. It was concerning that two years into compliance efforts, RGSC was not able to demonstrate a coordinated effort to obtain a measure regarding the services provided by the Facility. The second area of concern that stood out in the self-assessment was that the Action Plans typically lacked specific criteria for what was to be completed. For example, one step in the Action Plan consisted of the statement, "Train staff on active treatment and show them the expected outcome based on the monitoring tool." Although an admirable and appropriate goal, there was nothing in the specific action step or elsewhere in the Action Plan that provided objective and measureable details regarding this process. Compliance with a Settlement Agreement requires that the Facility invest considerable effort into taking the guidelines in the Settlement Agreement and identifying the specific actions necessary to meet those requirements.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RGSC from 2/27/2012 through 3/02/2012. Record reviews continued off-site following the site visit. Based upon information gathered during the current site visit, it was apparent that no provisions of Section S were found to be in substantial compliance with the Settlement Agreement or to show substantive improvement in comparison with previous findings. Throughout the site visit, staff often voiced the opinion that conditions at RGSC had improved substantially since the previous site visit. It did appear that many staff were more open to change and had greater investment in the compliance process. In multiple situations, however, the Facility was unable to demonstrate a coherent and measureable progression toward compliance with the Settlement Agreement. For example, assessment findings and information in the ISP often did not agree. In addition, skill acquisition programs did not reflect that skill assessments or preferences of the individual had been considered in the development process. Furthermore, the skill acquisition programs often failed to conform to accepted standards regarding task analysis. There exists a very real obligation for residential facilities to provide intensive and comprehensive teaching so that individuals increase independence and the probability for successful integration into the community. RGSC did not yet provide such teaching for skill acquisition and is not in compliance with the provisions of Section S.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with	A review of assessment and skill acquisition training records during the baseline visit revealed that for 18 of 18 individuals (100%) it was not possible to demonstrate that the	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>assessments upon which training programs were based were accurate or had identified real and meaningful needs. In August 2011, the site visit assessment revealed that 13 of 13 individuals (100%) lacked assessments that could be shown to be accurate or that had identified real and meaningful needs.

During the current site visit, 31 individuals were selected as a sample to assess the status of skill acquisition programs. For each individual, at least two Specific Program Objectives (SPOs) were reviewed. A portion of the review process included an audit of the ISP and assessments used by the Facility to identify individual training needs. Based upon the review, it was evident that the Facility had failed to progress beyond the conditions observed during the initial site visit in February 2010. The table below reflects the status of assessments noted during the current site visit.

<table>
<tr><td></td><td>02/2010</td><td>02/2012</td><td>Change</td></tr>
<tr><td>Skill acquisition plans are implemented to address needs identified in:</td><td></td><td></td><td></td></tr>
<tr><td>ISP</td><td>0%</td><td>6%</td><td>6%</td></tr>
<tr><td>Adaptive skill or habilitative assessment</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Psychological assessment</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Skill acquisition plans are chosen in an individualized manner.</td><td>0%</td><td>3%</td><td>3%</td></tr>
<tr><td>Skill acquisition plans are related to the individual’s preferences.</td><td>0%</td><td>3%</td><td>3%</td></tr>
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Of the 31 ISPs reviewed, only two included a specific discussion of assessments relating to the SPOs being reviewed by the Monitor. In most ISPs, the narrative reflected that skill acquisition goals were selected based upon the subjective opinion of staff attending the ISP meeting or anecdotal observations for which no substantiating data were presented. In several ISPs, conflicting information regarding the abilities of the individual was presented. Examples of the noted weaknesses are presented below.
• For Individual #115, the ISP reflected that the individual should learn ways other than a hug to greet people. No information was presented, however, to indicate the frequency with which the individual used hugs for greetings, why hugs were used by the individual, or how often other forms of greeting were used. As a result, there was no objective evidence that the goal was relevant for the individual. Neither was there sufficient to determine the most appropriate intervention strategies.
• For Individual #55, the ISP narrative reflected that the individual used money for purchases. The ISP also included statements that indicated the individual possessed no concept of the purpose of money. Although it was possible that</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		different assessments produced conflicting findings, one purpose of the ISP meeting is to resolve such conflicts and identify the most relevant training objectives. There was no indication that such a process was utilized in the development of the ISP. The most common process used at RGSC to assess adaptive skills and habilitative needs was the Functional Skill Assessment. The FSA reflected advancement from the previous PALS assessment. Rather than listing a variety of skills as either a strength or weakness, as was required by the PALS, the FSA was constructed more like a task analysis of a variety of skills. Each individual is rated by the level of prompting required for success on skill or task. This provided a more detailed representation of each individual's abilities. Despite the improvement represented by the FSA, it was not clear that the protocol was sufficient for skills assessment. One substantial limitation was the lack of granularity and individualization reflected in the FSA. For example, one item under "Meal Time Skills" was "Eats with a utensil." For some individuals, eating with a utensil would not be physically possible. For other individuals, extra time might be required to control fine motor coordination. These types of circumstances have no relation with the level of prompting required. The FSA included an area for comments on each item, but providing a comment about the inability of the FSA to measure the skills would not equate with assessing that skill. It would be unrealistic to expect that any instrument designed for the assessment of adaptive skills would possess the ability to capture all underlying circumstances for skill deficits. It is essential, however, that such an instrument include the means by which to measure the individual's abilities in the context of the individual's physical, developmental, cognitive, and environmental circumstances. Without the ability to capture the basic information about individual abilities within these contexts, any assessment results would be of unclear benefit in understanding the individual's needed supports and services, or in the development of skill acquisition plans. In many available instruments, this limitation is in part addressed by standardizing the instrument across variables such as physical ability, intellectual ability and living environment. The FSA reviewed at RGSC was not a standardized instrument. Therefore, a greater burden is created to ensure that the findings of the FSA provide individualized and relevant insights into the needs of the person being assessed. Based upon the review at RGSC, the FSA was unable to meet this burden. In addition to the general limitations presented by the design of the FSA, the records reviewed at RGSC also reflected substantial weaknesses in the application of the FSA. Numerous circumstances were noted where the findings of the FSA were not in	

#	Provision	Assessment of Status	Compliance
		agreement with the goals included in the SPOs. • For Individual #127, the FSA indicated the individual was able to wash his back with independence. The ISP reflected that one SPO for this individual was intended to teach him to wash his back. • For Individual #55, the FSA reflected that the individual refused to use communication devices. The ISP, however, recommended an SPO that included the use of a communication wallet. • For Individual #63, the FSA reflected that the individual frequently misplaced her eyeglasses. There was no mention in the FSA or ISP regarded dirty eyeglasses. The selected SPO, however, involved teaching the individual to clean her eyeglasses. Other assessment procedures in addition to the FSA were implemented at RGSC, such as the Personal Focus Assessment (PFA), the Vineland Adaptive Behavior Scales (VABS), and various intellectual assessments. The PFA is a rating tool intended to identify personal preferences. Ratings and identified preferences were noted to be entirely subjective and frequently based upon anecdotal evidence. Furthermore, references to the PFA in the ISP were, at best, sporadic. The lack of an adequate preference assessment was particularly concerning in relation to reinforcement for successful display of a skill. Reinforcement is essential for learning and must reflect the unique motivations of the individual. For the vast majority of SPOs reviewed, the reinforcement for a successful display or trial was verbal praise. It is not uncommon for verbal praise to function as a reinforcer. When virtually all SPOs include the same reinforcer, however, the probability of an individualized preference assessment being conducted is very low. Undoubtedly, for some individuals at RGSC, the verbal praise did function as a reinforcer. Due to the lack of adequate preference assessment, however, those occurrences most likely reflected chance or coincidence. Since the previous site visit, RGSC had become more aggressive in the assessment of intellectual and adaptive abilities. By the time of the current site visit, all individuals living at RGSC had received a standardized adaptive and intellectual assessment. As a result, the IDT had been provided with recommendations regarding abilities and the implications for skill acquisition training. This reflected a substantial step forward for the Facility. Unfortunately, none of the ISPs reviewed during the current site visit reflected that these findings or resultant recommendations had been considered in the selection and development of skill acquisition programs. Based upon the examples noted above, as well as several others, it was apparent that RGSC was frequently unable to ensure that assessment findings were used in the development of skill acquisition programs. When combined with the limitations in the	

#	Provision	Assessment of Status	Compliance
		design of the FSA and the PFA, it was evident that an individualized and evidence-based approach to program development was not utilized at the Facility. As a result, the Facility lacked the ability to ensure that individuals living at RGSC were provided with meaningful and functional skill acquisition training. The inability of the Facility to provide meaningful assessment of skills and abilities, and ensure that adequate SPOs were developed, was reflected in the majority of SPOs reviewed during the current site visit.	

	02/2010	02/2012	Change
Plan reflects development based upon a task analysis	0%	0%	0%
Behavioral objective(s)	0%	0%	0%
Operational definitions of target behavior	0%	0%	0%
Description of teaching conditions	0%	0%	0%
Schedule of implementation plans for sufficient trials for learning to occur	0%	0%	0%
Relevant discriminative stimuli	0%	3%	3%
Specific instructions	0%	0%	0%
Opportunity for the target behavior to occur	0%	45%	45%
Specific consequences for correct response	0%	0%	0%
Specific consequences for incorrect response	0%	0%	0%
Plan for maintenance and generalization that includes assessment and measurement methodology	0%	0%	0%
Documentation methodology	0%	0%	0%

The limitation in SPOs with perhaps the greatest negative consequence involved task analyses. RGSC relied almost entirely upon SPOs that involved sequential training procedures such as forward and backward chaining. When using sequential training methods, it is essential that a task analysis be completed. A task analysis is a formal process of breaking a complex skill into smaller, teachable units or tasks. None of the SPOs reviewed at RGSC were based upon a task analysis.

One result of the lack of task analyses involved the training steps included in the SPOs. The product of a task analysis is a series of sequentially ordered steps, unique to the individual, that are incorporated into a training program. These steps should involve observable and measureable behaviors that will be displayed by the individual being trained. The SPOs reviewed at RGSC reflected numerous limitations and weaknesses associated with poor task analyses.

- For Individual #115, an SPO for writing a letter to family included five steps; four of those steps reflected behaviors that staff rather than the individual were to

#	Provision	Assessment of Status	Compliance
		display. The single step that targeted a behavior to be displayed by the individual involved allowing the individual to observe the task, a behavior that was neither observable nor measureable. • For Individual #115, an SPO for learning alternate greetings reflected a sequential training methodology. The skills being taught, however, were discrete behaviors rather than steps in a larger task or behavior. • Individual #4 was provided an SPO for learning cooking skills. All steps in the SPO involved behaviors to be displayed by staff rather than the individual. • Individual #63 was provided an SPO for cleaning glasses. The SPO did not involve an initial step of determining whether the glasses were in need of cleaning. This was particularly problematic, as the SPO later required the individual to compare the "cleaned" lens with the "dirty" lens. In discussions with staff regarding task analysis and SPO steps, staff repeatedly assured the Monitor that it was appropriate for SPOs to include steps that reflected staff rather than individual behavior. Staff also indicated that such steps were particularly appropriate for individuals with fewer skills. It was not reflected in comments that staff recognized such steps actually inhibit learning by denying the opportunity of reinforcement for behavior displayed by the individual or offering reinforcement for behaviors other than those that are components of the overall skill being taught. Furthermore, the staff did not recognize that using training methods that involve teaching multiple tasks in a sequence could be too complex for people with fewer abilities and skills. In such cases, a training method that teaches less complex, single behaviors, known as discrete-trial training, could be more appropriate.. These circumstances reflected the need for training for those staff tasked with developing SPOs. It was evident the lack of task analyses substantially contributed to several weaknesses noted in SPOs. Other limitations, however, were also noted in SPOs. • The criteria included for the majority of SPOs included a minimum of 12 trials per month. Data sheets, however, reflected only between four and eight trials per month were completed. • None of the SPOs reviewed identified teaching conditions, such as how the teaching area was to be prepared, where teaching was to occur, and how materials were to be presented. • None of the SPOs reviewed included specific discriminative stimuli or antecedents for the behavior to be learned. For example, the SPO for learning alternate greetings for Individual #115 did not include any indications for the individual of when a greeting was appropriate and could be delivered. Based upon the information obtained during the site visit, it was evident that RGSC was	

#	Provision	Assessment of Status	Compliance
		unable to ensure that the individuals living at the Facility were provided with adequate learning opportunities. Furthermore, the status of skill assessment and skill acquisition training had not appreciably improved since the baseline visit in February of 2010. During the initial site visit in February of 2010, reviews of the records for 18 individuals, as well as observations of those and other individuals in a variety of settings reflected an overall inability by RGSC to provide reasonable levels of individualized engagement. In several settings, there was a pervasive lack of engagement. Problems noted at that time included a lack of training materials, individuals who reported a preference for being away from vocational activities, and a lack of meaningful engagement in a variety of settings. Observations and record reviews conducted during the August 2011 site visit reflected no substantive change from conditions noted in February of 2010. During the current site visit, the Facility reported that a system for monitoring engagement and active treatment had only just been implemented. Preliminary data from the Facility monitoring process were available and reflected that active engagement was noted during 69% of observations. During the site visit, the monitor conducted 20 independent observations in various settings throughout the RGSC campus. This process reflected functional engagement for only 39% of observations. One potential reason for higher ratings of engagement by the Facility involved errors in the ratings. For example, a Facility rater scored an observation as involving engagement when it was noted that the individual was asleep. A second rating indicated engagement although the narrative of the report reflected that the necessary communication devices were unavailable. A second potential reason for the higher ratings by the Facility involved the difference between engagement and functional engagement. An individual may be engaged in an activity without that engagement comprising the functional use of a skill. For example, during the site visit, an individual was observed picking up small items around a trashcan and placing them in a one-pint milk carton. Although the person was engaged in an activity, the activity did not provide a functional purpose for the individual. If, however, the individual was provided the opportunity to utilize this behavior as part of a formal effort to teach lawn or grounds care skills, the behavior could become substantially more functional. Several of the ratings of engagement conducted by the Facility did not include differentiation between engagement and functional engagement.	

	01/2010	02/2012	Change
Overall, the set of skill acquisition programs promote growth, development, and independence	0%	0%	0%

#	Provision	Assessment of Status	Compliance

	Staff Present	Individuals Present	Individuals Functionally Engaged	% Engaged
502 Dining Room	5	6	3	50%
502 Dining Room	5	7	3	43%
502 Lobby	0	1	0	0%
501 Dining Room	5	7	7	100%
501 Lobby	0	1	0	0%
501 Women's Living Room	0	1	0	0%
502 Lobby	2	7	5	71%
502 Women's Living Room	1	1	1	100%
502 Men's Living Room	1	5	0	0%
TR 21	1	4	3	75%
TR 16	1	3	1	33%
TR 15	2	6	2	33%
TR 11	1	5	4	80%
TR 16	2	6	0	0%
TR 14	3	9	1	11%
502 Lobby	2	6	2	33%
501 Women's Living Room	1	4	1	25%
501 Men's Living Room	1	4	1	25%
501 Lobby	1	3	0	0%
502 Women's Living Room	2	2	2	100%
Mean Percentage of Engagement				39%

During observations conducted by the Monitor, several circumstances reflected an inability by the Facility to ensure functional engagement.

- At 7:30 on the morning of February 28, five individuals were offered no interaction or activity by staff. Several of these individuals were displaying stereotypic behavior. One man attempted to engage a staff member in conversation, but the staff member ignored him.
- On Monday February 27, staff at a Quarterly ISP review reported that Individual #140 was sleepy in the morning due to medications and had difficulty arriving at work by 8:00am. It was decided that the individual's work hours would be shifted so that arrival at work was to occur at 9:00am. During observations on the morning of February 29, it was noted that Individual #140 was in bed at 9:00 am. When asked, staff reported that the individual often slept until 10:00 am. Staff was unaware of the discussion that had occurred at the meeting two days before.

#	Provision	Assessment of Status	Compliance

- At 9:15 am on February 29, Individual #21 was observed sleeping in the telephone room in residence 502. The individual was sound asleep with his hand in his pants, his shirt over his head, and an empty drink bottle next to him. When asked, staff reported that the individual preferred to sleep and it was often difficult to engage him.
- At 10:00am on February 29, staff in Training Room 15 had made training materials available. No encouragement or interaction was provided by staff, and individuals in the room were either asleep or engaged in stereotypic behavior.
- At 10:15am on February 29, Individual #80 was observed in Training Room 16. The individual slapped his neck and face in excess of five times. Although staff was present, there was no redirection or intervention. This was of particular concern, as the individual had been identified as being at risk of serious medical harm due to self-injury.
- At 3:07pm in the Women's Living Room on residence 502, three of four individuals were observed to have no materials available and were provided with no functional engagement. When the Monitor entered the room, one of two staff in the room was engaged in watching television.

There were circumstances where staff was attempting to provide engagement and functional activities. For example, at 3:15 on February 29, a single staff member was attempting to organize activities for four individuals in a living room on residence 502. The staff reported that it was very difficult to attend to the needs of all individuals because the residences were frequently understaffed, as was the case on the day of the observation. Situations in which functional activities were provided typically appeared to occur by chance rather than by systematic or organized efforts. In addition, several staff reported that the level of activity treatment and functional engagement during the site visit was substantially better than what typically occurred.

	02/2010	02/2012	Change
A plan is in place to address, monitor, and maintain reasonable levels of individual engagement in all settings at the facility, including residences, day programs, and work sites.			
Preferred activities are available	0%	1%	1%
Leisure activities are available	0%	16%	16%
Vocational and work programs and activities are available	0%	13%	13%

Based upon the observations conducted during the site visit, the Facility did not have a functioning plan in place to ensure functional engagement for the individuals living at the

#	Provision	Assessment of Status	Compliance
		Facility. Furthermore, the plan that had recently been implemented did not reflect reliable and valid measures of functional engagement. Despite modest improvement in engagement, the status functional engagement at the Facility was not appreciably better than observed during the initial baseline site visit.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	The Facility indicated that at the time of the site visit there were no data to support annual habilitation assessments for 100% of individuals living at the Facility. A review of records reflected that an assessment process did take place on an annual basis. This assessment process conducted as part of the ISP 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. At the time of the site visit, the Facility had completed adaptive and intellectual assessments for all individuals living at RGSC. There was no indication in the available records, however, that the results of the assessments were used in the formulation of skill acquisition goals and programs during the ISP. Other than the intellectual and adaptive assessments, 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 preferences were identified consisted primarily of subjective opinions from staff; no formal preference assessments were completed. 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.	Noncompliance
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions,	Due to the limitations noted in Provisions S1 and S2, it was frequently not possible to	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>determine if training programs addressed pertinent needs of the individual. Without accurate and comprehensive assessment, it was not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. As a result, it was probable that RGSCC did not possess a clear measure of each individual's strengths and needs, and could not develop, monitor or revise training programs with accuracy.

As documented in Provision S1 of this report, several observations were conducted of residences and training areas at RGSC during the current site visit. During these observations, no implementation of formal teaching was noted. Even in circumstances where individuals were functionally engaged, staff was not observed in the act of systematically using reinforcement to strengthen new behavior. Several circumstances were noted, however, in which training was not provided according to identified needs or written training procedures.
• The dining card for Individual #140 indicated the individual was capable of eating independently. Staff were observed cutting the individual's food during meals.
• For Individual #115, all training data sheets for February were blank.
• Individual #3 was observed picking up small items around a trashcan and placing them in a milk carton. Staff briefly interrupted the behavior but did not provide on-going intervention or teaching. The individual was observed engaging in similar behavior several more times within the hour.
• Thirty-one of 33 data sheets to document the teaching of replacement behaviors during February 2012 were blank.

Of particular concern during the site visit were comments offered by several staff, including those in supervisory or administrative positions, that too much emphasis was placed upon collecting data. One of the critical components in the development and implementation of skill acquisition programs is the reliance upon an evidence-based approach to teaching. The failure by staff to recognize the importance of data collection to teaching, as well as to compliance with the Settlement Agreement, suggested that the Facility was not prepared to offer the necessary services.

<table>
<tr><th></th><th>02/2010</th><th>02/2012</th><th>Change</th></tr>
<tr><td>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>As assessed by staff report.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>As assessed by observation.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Plan is implemented according to the specified schedule.</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>
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<tr><td></td><td>Reinforcement is used appropriately.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td></td><td>Prompting and practice are used appropriately.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td></td><td>Plan is practical and functional in the most integrated setting.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td></td><td>Data are graphed.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td></td><td>The plan is producing meaningful behavior change.</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>

Based upon observations and record reviews during the current site visit, there was little indication that the Facility had progressed beyond baseline conditions.
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<tr><td></td><td>(b) Include to the degree practicable training opportunities in community settings.</td><td>Data provided by the Facility during the current site visit did not provide a clear picture of community training activities. In one document, the Facility reported that 21 individuals had participated in training in a community setting during the previous six months. In a separate document, however, the dates for community training by the Facility indicated 69 individuals had participated in community training since the previous site visit. Furthermore, RGSC reported that documentation did not exist for community outings that did not involve training.
<table>
<tr><th></th><th>02/2010</th><th>02/2012</th><th>Change</th></tr>
<tr><td>Each individual is provided with training in the community that appropriately addresses his/her needs and preferences.</td><td>0%</td><td>0%</td><td>0%</td></tr>
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Without adequate data and documentation, it was not possible to determine the status of community-based training at RGSC.
</td><td>Noncompliance</td></tr>
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Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. RGSC should develop and implement a system to ensure that the ISP process is successful in accurately identifying needs of the individuals living at the Facility and providing skill acquisition programs to meet those specific needs. It would be beneficial if the process for identifying individual needs were broadened to include more than the FSA. A standardized adaptive skill assessment used in combination with thorough task analyses should be considered. The use of a formal preference or reinforcer assessment in addition to the PFA would also be helpful in identifying powerful reinforcers to use in skill acquisition programs. (Provisions S1, S2)
2. The current system used to monitor and increase active treatment appears to lack validity and reliability, and monitoring efforts do not appear to have appreciably increased formal training or informal engagement in functional skills. RGSC should consider a more rigorous system for this task that includes specific objective measures, provides for greater validity and reliability, and that reflects a more evidence-based approach. Such a system that also included clearly identified goals, specific timeframes, and a plan of response for when goals were not met would be very beneficial. (Provision S1)
3. RGSC should obtain extensive training in the development of skill acquisition programming for the staff responsible for developing and

implementing skill acquisition programs. This training should include the design and implementation of task analyses, the development of both sequential and discrete-trial training programs, and the development of data collection and presentation strategies for monitoring the acquisition of skills. (Provisions S1, S3a)

4. RGSC should facilitate among staff the recognition that skill enhancement and behavior change require an empirical, evidence-based approach. Staff that fail to recognize this requirement and that downplay the importance of valid and reliable data are counterproductive to the Settlement Agreement process. (Provision S3a)

The following are offered as additional suggestions to the Facility:

1. Data and an evidence-based strategy are critical to the development of a system that meets compliance criteria within the Settlement Agreement. RGSC must act diligently to identify specific weaknesses in the current system, establish specific goals and timeframes for each need, and utilize valid and reliable data to assess progress toward those goals. The current Self-Assessment – Action Plan too frequently reported no data were available and indicated changes had yet to be implemented that had been discussed more than a year prior to the site visit.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-Assessment and Action Plan 2/13/12 2. RGSC Section T Presentation Book 3. DADS Policy 018.1 Most Integrated Setting Practices 3/31/10 4. RGSC SOP ICF-MR 200 01 Most Integrated Setting (April 2011) 5. Individual/ Personal Support Plans (ISPs/PSPs) for Individuals #13, #26, #27, #55, #59, #61, #63, #77, #80, #84, #85, #88, #97, #121, and #139 6. Personal Focus Worksheet for Individual #27 and #55 7. List of individuals who had been transferred to community settings since the last compliance visit 8. Documents related to the movement of Individual #145 to a more integrated setting, including Community Living Discharge Plan (CLDP) 9. CLDP for Individual #107 10. Draft CLDPs for Individuals #13, #80, and #121 11. Pre-Move Site Review documents (prior to site review) for Individuals #13, #80, and #121 12. Active Record of Individual #80 13. Email from Alma Ortiz to Mary Ramos of 2/28/12 on status of draft CLDPs for Individuals #13, #80, and #121 14. Annual Medical Assessment and other medical documentation for Individual #80 15. Pre-move Site Review form for visit of home for Individuals #13, #80, and #123 16. Post-Move Monitoring (PMM) Checklists completed for Individuals #39, #107, and #145 17. List of individuals who had have been referred for community placement by the PST since the last compliance visit 18. List of individuals who had requested community placement since the last compliance visit but had not been referred 19. List of individuals who had not been referred solely due to LAR preference since the last compliance visit 20. List of individuals who, for the last one year, have transitioned to the community, indicating whether they have had police contact, psychiatric hospitalization, ER visit or unexpected hospitalization, unauthorized departure, transfer to a different setting, dies, returned to the Facility (Response: "NA") 21. Annual Report: Obstacles to Community Transition, Fiscal Year 2011, Data as of 8/31/2011 22. Sign-in Sheets for the Provider Fair of 12111 for consumers, families, and RGSC staff 23. Sign-in Sheets for MRA Training provided to RGSC staff by Tropical Texas MRA 24. Signature Sheets for tours of community settings for Individuals #93 and #115, with completed questionnaires **People Interviewed:** 1. Alma Ortiz, Admissions/Placement Coordinator (APC)

	Meeting Attended/Observations: 1. Review Meeting for Individual #145 2. ISP Meeting for Individual #97 3. Pre-move site visit of home for for Individuals #13, #80, and #121 4. Advocates (self-advocacy council) meeting of 2/28/12
	Facility Self-Assessment: The Facility provided two documents intended to present the status of current efforts to comply with the Settlement Agreement. The first was a Self-Assessment reflecting measures of progress. The second was the Action Plan that outlined the steps the Facility had identified as critical to satisfying the Settlement Agreement. The Facility's Self-Assessment Report included the activities the Facility engaged in to conduct the self-assessment and self-ratings based on the findings. Based on these activities, the Facility rated Provisions T1b1, T1b2, T1b3, T1c1, T1c2, T1c3, T1g, T1h, and T2 in substantial compliance, and the rest of the provision noncompliant. The Monitoring Team rated only Provisions T1c3 and T1h in substantial compliance. Although the issues leading to discrepancies in ratings will be made clear in the findings, following are some comments to assist the Facility to improve its self-assessment. For Provision T1b1, the Facility rated compliance based on starting the CLDP process and discussing supports and services when the individual was referred. However, Provision T1b1 requires that obstacles to movement be listed and strategies to overcome those obstacles be identified and implemented. Assessment needs to be done of the accuracy of identifying obstacles and of having strategies in the ISP to overcome them. For Provision T1b2, the Facility listed a set of accomplishments as evidence of compliance. The Monitoring Team agrees that these were important accomplishments related to the requirements of the provision. However, the Facility had not developed individualized plans to educate individuals about more integrated settings. Aside from the provider fair and CLOIP, the most prominent aspect of education provided by the Facility was individual tours of group homes and day programs, but there had been no evaluation of effectiveness of this process, the number of tours remained somewhat limited (or, at least, no data were provided regarding number of tours and number of individuals who have toured), and an organized process for these tours had only recently been implemented. The tours were an excellent approach, and the new organized process shows promise, but implementation had not reached a point where it could be considered adequate for compliance, especially with little other individualized education activity in place. For Provision T1b3, the Facility reported all individuals have been assessed for placement at annual ISPs or as needed. The Monitoring Team found that discussions were not substantive, and individual professionals had not provided in their assessments determinations about appropriateness of referral. The Facility will need to assess both quality of discussion and whether professionals provide individual determinations. The Facility could also provide data it already collects on the numbers of individuals newly referred for movement as well as information on outcomes and IDT discussion of exploration activities such as tours of

	community living and work settings. The Action Plan for training IDT members on documenting living options discussions may help. For Provision T1c1, the Facility stated for 100% of individuals referred for placement, the IDT identified all essential and non-essential supports needed. As reported in both Section F and in this provision, IDTs have not consistently identified supports adequately, even in ISPs. The Facility needs to assess identification of support needs more accurately. Also, because this provision requires the Facility to specify actions to be taken by the SSLC to implement the CLDP, there should be some assessment of whether this has been done. For Provision T1c2, the Facility did not, but should, assess whether Facility staff responsible for implementing or monitoring to ensure implementation of transition actions are identified by name. For Provision T1g, the Facility stated DADS state office had reviewed and accepted the Facility's obstacle report. However, the listing of obstacles in the report was not yet complete. Furthermore, the report stated the Facility did not yet collect data consistent with the DADS Most Integrated Setting policy and had developed and implemented a data collection process as outlined in policy; this issue was not identified in the Facility Self-Assessment but should be for the next visit. Because the next Obstacle Report will not be due by the next compliance visit, the Facility should assess its collection of data up to the point of the visit. The Facility provided an Action Plan of activities to progress toward compliance. Much of this consisted of diverse activities but not a sequential plan to reach specific goals. The plan for Provision T1d instead provided a sequence of steps that should lead toward compliance with the requirements of that provision. The plan for Provision T1e, on the other hand, listed steps needed for each move but did not identify how to ensure those steps will occur consistently. Furthermore, because identification of supports and services needed by the individual is so closely tied to development of an integrated plan of services and supports, the action plan for Section T should involve some level of coordination with the action plan for Section F.
	Summary of Monitor's Assessment: The Facility stated in its Obstacles to Transition report for FY 2011, and the Monitoring Team confirmed through observation of an ISP annual planning meeting and review of numbers of referrals and of CLDPs, that there had been a "paradigm shift by the PST whereby individuals' special needs are not seen as obstacles to placement but areas in need of additional supports." As a result, the number of individuals referred for community living had grown significantly. There had been some growth in the number of people who actually moved, and this was expected to continue; however, the Facility will need to identify how to provide additional resources to the single staff who has been responsible for preparing CLDPs and working with MRAs to identify providers. The Facility was continuing to implement actions to encourage individuals and LARs to move to the most integrated settings appropriate, but there had not yet been individualization of these actions. The Facility provided and encouraged tours of community settings but did not have a process in place to evaluate the effectiveness of these tours. Nevertheless, the outcome of increased referral and movement provides some indication that efforts to encourage movement have met with some success.

	Perhaps the most significant concern of the Monitoring Team is equally relevant to Section F. The identification of protections, services, and supports needed for provision of adequate habilitation in the most integrated appropriate setting is an outgrowth of the identification of supports and services through the Facility's ISP process. This needs improvement in order to ensure Community Living Discharge Plans (CLDPs) adequately reflect the needs of each individual for protections, supports, and services. DADS requires that all professionals report, in assessments, their determination of the appropriateness of movement to a more integrated environment, so that the IDT can make a decision about referral. This was not consistently done. ISPs did not provide evidence that discussion of appropriateness of referral was comprehensive and adequate enough to serve as an assessment for placement. Nevertheless, the outcome of increased referral indicates that the paradigm shift described above has affected the assessment outcomes. CLDPs were not always completed timely, in part because of delays in provision by professionals of required assessments. CLDPs did not identify individual staff responsible for implementing or ensuring implementation of required supports. Post Move Monitoring visits were reported to have been made timely; however, documentation was not provided to the Monitoring Team, so it is not possible to find substantial compliance. Overall, the Monitoring Team commends the Facility for the change in approach to encouraging movement to more integrated settings and looking at needs in terms of supports needed rather than obstacles to movement. Improved identification of services and supports needed, leading to more comprehensive lists in CLDPs, will be needed for compliance. Assessments will need to be provided timely. Professionals will need to document in their assessments determinations of appropriateness of referral. The Facility has made progress and now needs to ensure all required actions are done consistently.

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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	<u>Policies and Procedures related to Movement to the Most Integrated Appropriate Setting</u> DADS Policy 018 Most Integrated Settings prescribes procedures for encouraging and assisting individuals to move to the most integrated setting, to identify needed supports and services, to identify obstacles to movement, and to conduct and document post-move monitoring. This policy requires each State Center to "encourage and assist individuals to be served in the most integrated setting appropriate to their needs." An updated DADS policy remains in draft. RGSC SOP ICF-MR 200 01 Most Integrated Setting repeats the requirements of DADS policy with minor wording revisions to localize it.	Noncompliance

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	integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	Transition Outcomes During Last Six Months • Community Transitions: Three individuals (4% of the 71 individuals in residence at the time of the last compliance visit) had moved from RGSC to a more integrated setting since the last compliance visit. This was an increase from one person (1%) during the prior six months and reflects improvement in meeting the requirements of this provision. • Referrals for Community Transitions: Fifteen individuals (21% of the 70 individuals in residence at the time of this compliance visit) were on a referral list. This was a significant increase over the nine individuals on the list at the time of the last compliance visit. Nine individuals had been added to the referral list since the last visit, and three individuals had moved. Of the 15 individuals on the list for referral, seven (47%) had been on the list for over 180 days. Of that group, three individuals were scheduled to move the week following this compliance visit, and a pre-move site visit was held during the compliance visit. No clear explanation was available for the delays in movement. However, the APC was responsible for referral activities, as well as for development of CLDPs and for providing information to staff; a resource of one person might not have been adequate to provide regular and consistent follow up in the referral process and to coordinate with the MRA activities to ensure necessarily supports and services would be available. DADS had begun the process of hiring Transition Specialists to assist SSLCs and RGSC to provide information to individuals, families, LARs, and staff about community living, and to help develop effective means of communication and information about community resources. The Monitoring Team will review how this new resource assists in increasing the pace of referral and movement. • Outcomes of Transitions: No individual who had moved in the prior year had returned to the Facility. However, a meeting was held with the Facility, provider, Mental Retardation Authority (MRA), and mother to discuss whether Individual #145 should return to live at the Facility due to psychiatric hospitalization. The determination was that the individual would not return, but instead, the RGSC psychiatrist would consult with the hospital psychiatrist to determine the next action (options included a brief stay in the RGSC mental health program that is separate from the ICF/MR as well as an offer of consultation from the RGSC psychiatrist to the community provider.). No deaths had occurred among the people who had moved, and the only hospitalization reported was for Individual #145 (whose hospitalization followed	

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		the completion of the Facility response to the document request). <u>Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting</u> As described in Provision T1b2, the Facility conducted educational activities for individuals and for staff to make them aware of community living opportunities, as well as to inform staff about the materials available to inform individuals and families/LARs. Also, the APC provided training to a few staff about the process of group home tours. During the last compliance visit, the APC reported that she was working on a questionnaire for staff to take on group home tours to ask whether the home can provide the supports an individual needs. The Facility provided signature sheets for the staff who accompanied Individuals #93 and #115 on tours; copies of the questionnaires were also provided. This brief questionnaire provided information that staff might find useful in recommending specific providers to serve an individual. 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 eight ISPs selected by a computerized random number generator for Individuals #26, #59, #63, #77, #84, #85, #88, and #139. In seven ISPs (83%), the ISP contained documentation that community living materials were provided to either the individual, the family/LAR, or both; for Individual #84, the ISP documented that the LAR stated she was familiar with community living. All ISPs documented the presence of the MRA at the ISP meeting (with Designated MRAs at seven meetings and Contract MRAs at six). For some individuals, the ISP documented that the individual did not respond to the materials provided or to questions about preferences. The ISPs also documented that only one of the individuals had toured community homes; one was not a legal resident and therefore was ineligible for funding, and LARs for two individuals refused tours. For several people, the IDT recommended exploring tours, but this was listed as a Service Objective only for Individual #26. Family was not able to attend the ISP annual planning meeting for Individual #97 observed by the Monitoring Team. Individual #97, who was present, did not participate. Nevertheless, the IDT decided to explore group homes in the area where the individual's parents live. The Monitoring Team reviewed minutes of the Advocates (self-advocacy council) meetings and attended the meeting held during the compliance visit. Although minutes did not include documentation of discussion about where to live, there was discussion during the observed meeting. Two individuals expressed that they wanted to move to a	

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		group home. The ISP for Individual #61 reported that the individual had not gone on a tour of community settings in the prior year, and the IDT had agreed to refer for group home tours; this plan to refer was included in a Service Objective (with "How Often" listed as "Once" and without a completion date). For Individual #139, there was an action plan to arrange tours for the individual and his mother; "How Often or Due Date: was listed as "Before moving." Although it was encouraging to find that the IDT recognized the individual's interest and made a formal plan to refer for tours, it would be better if the ISP actually planned tours (rather than simply referring for tours), identified a specific plan, and included an expectation that this would occur more than once. The Facility had not taken action to evaluate the effectiveness of activities to encourage movement. However, the significant increase in number of individuals proposed for referral would indicate that something—whether it is encouragement to the individuals and LARs or to staff—had been effective. Although RGSC was not yet in compliance with this provision, significant progress had been made in increasing referrals.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	<u>Policies and Procedures</u> As reported in Provision T1a, there were both a DADS and a Facility policy. A revised DADS policy was reportedly in draft. The RGSC action plan is to incorporate the revised DADS policy, when released, into Facility policy. The Facility remained out of compliance with the implementation of the policy. This is discussed below with regard to each of the subsections of provision T.1.b of the Settlement Agreement. As a result, an overall finding of noncompliance has been made for Section T.1.b.	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	DADS was reported to be in process of revising the ISP format, both for documentation and for process. Although RGSC staff had been trained in the current ISP and facilitation processes, the ISPs and the ISP meeting did not demonstrate progress, as documented in Section F. The Monitoring Team wishes to acknowledge the efforts by DADS to continue to work to improve the ISP process and will be interested in determining how the revised process will improve identification of services and supports needed for movement. <u>Identification by the IDT of Protections, Services, and Supports That Need to be Provided in the Most Integrated Appropriate Setting</u> The Monitoring Team reviewed the following: • Eight randomly selected ISPs for Individuals #26, #59, #63, #77, #84, #85, #88, and #139	Noncompliance

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	integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	• The ISP for Individual #61, who had stated she wanted to move to a group home • The ISP for Individual #97, whose ISP annual planning meeting was observed by the Monitoring Team • The ISPs for the last two individuals who had moved to a more integrated setting, Individual's #107 and #145 • The last ISP completed for each of the two residences, Individuals #27 and #55 The ISP 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 as part of the third quarterly review by the individual, family/LAR, and PST. Review of these ISPs revealed that five of 14 Personal Focus Meetings (36%) were documented in the ISP as occurring the same day as the ISP annual planning meeting, four (29%) were documented as occurring the prior quarter, two (14%) were documented as occurring two weeks prior to the ISP meeting, one (7%) was documented as occurring a year prior to the ISP meeting, and one (7%) was undated. As no PFA meeting was scheduled during the visit, the Monitoring Team could not observe the process. In response to requests for assessments, the Facility provided no PFA documents. In the ISPs reviewed by the Monitoring Team, each provided a list of preferences identified at a Personal Focus Meeting; these preferences primarily involved foods and activities, and in some cases relationships with family, but did not include information on preferred living settings and therefore did not appear to be used in determining the Optimistic Living Vision. Personal Focus Assessments were provided for Individuals #27 and #55. The PFA for Individual #55 was dated three months prior to the ISP annual planning meeting as required by policy. The PFA for Individual #27 was dated approximately two week prior to the annual planning meeting. The PFA for Individual #27 summarized the individual's day-to-day preferences, but the PFA for Individual #55 did not provide a summary of the responses to the lengthy list of questions on the form; nevertheless, the ISP included a list of day-to-day types of preferences. One preference that would be useful in a more integrated setting was "turn on the television," which was listed in response to one item on the PFA and was included in the list in the ISP; however, no action plan was established to either teach the individual to turn on the television or to provide assistive technology to make this possible. No item on the PFA indicated an interest in using a vending machine, nor was it included in the ISP list of preferences, and it would not address any obstacle to movement to a more integrated environment, yet that was one	

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		teaching goal in an action plan. This was one example of the lack of use of information from the PFA in planning services and supports. For Individual #27, one response to a PFA item was that the individual expressed an interest in learning how to work outside in the community and earn extra funds. Although this was not listed in the summary of preferences that was transferred to the ISP, "Money, "Vocational services," and "Community outings" were on that summary list. There was no action plan that responded to this interest, either by planning to explore community employment, to establish a higher-paying vocational opportunity on the Facility campus, or providing any other relevant training that might increase likelihood of community employment. This was a second example of the lack of use of information from the PFA in planning services and supports. The section of the ISP found under Optimistic Living Vision and titled "The supports and services needed by "Name" in the areas of:" lists a number of standard areas or disciplines such as "Physical Environment (home)" and "OT/PT" that each have a description that may include diagnoses, medical and behavioral problems, supports such as assistive equipment being provided at the facility, and (in some areas for each individual) supports that would be needed in a more integrated setting. In many cases, the supports may be found in the middle of a paragraph that includes other information, so it is difficult to ascertain specifically what is being recommended. The only ISP that included a listing of all supports that would be needed in a more integrated setting was for Individual #77, so it is difficult to determine how comprehensive the lists are. Each of the 11 ISPs reviewed included some supports. However, only one (8%) of the ISPs included a comprehensive list of supports. (Individual #63) There are numerous examples in which the supports identified in the listed areas were not comprehensive. For example: • For Individual #88, diagnoses of seizure disorder and hypothyroidism were reported in the Medical section, along with the medications currently prescribed. The need for chairs with arm rests for seizure precaution was listed in Physical and Nutritional Management, so there was no place in which all supports that addressed seizures were listed together. However, there were no recommendations for supports needed to address either seizures or hypothyroidism unless one would consider that continuing the current regimen is the recommendation (but that is not stated, and no other recommendations for medical follow-along were made). • For Individual #39, the Speech/Audiology area reported a communication book was being developed but did not mention supports that would be needed in a more integrated setting, including making contents of such a communication book relevant to that setting.	

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		• For Individual #26, the Physical Environment section noted the need for a one-level home with even surfaces and no stairs to prevent falls and states the individual requires an AFO (ankle foot orthotic). The OT/PT section did not comment on supports needed to maintain an AFO, and neither that section nor the Physical and Nutritional Management section mentioned supports needed to minimize falls. As described in Provision F1e, professionals did not, in their assessments, identify the most integrated setting appropriate to an individual's needs. Professionals have individual responsibilities to make specific recommendations about the most integrated setting appropriate for an individual. The State Office had provided a directive that each SSLC team member must include in his/her assessment/evaluation a recommendation regarding the individual's appropriateness for transition to a more integrated setting, and delineation of the supports the individual would need. As was discussed at the parties' meeting in June, in addition to assessors providing recommendations in each of their assessments, the determination of the professionals on the team should be documented clearly in the ISP. The professionals' recommendation should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition. The requirement of providing a determination of the most integrated setting currently appropriate had not been fully implemented. For example, for Individual #97, the Comprehensive Nursing Assessment stated the professional's determination that the individual can be served in a less restrictive setting. The OT/PT Comprehensive Assessment had no category for this determination but did have a heading of "Factors for Community Placement" in which the assessment stated the individual "is available for assessment" but did not provide a determination or recommendation. The Speech-Language Evaluation had the same heading, under which was provided a list of supports that would be needed in a more integrated setting but did not provide a determination of the most integrated appropriate setting. The Facility needs to establish a consistent process, provide training, and monitor to ensure each professional provides a determination. The ISP annual planning meeting for Individual #97 demonstrated that professionals did, in fact, have recommendations about movement to a more integrated environment. A focus of the meeting was on consideration of moving to a group home. Although the individual's parents told the MRA they preferred the individual remain living at RGSC, the IDT discussed informing them of group homes near where they live and the supports that would be needed for the individual to move successfully. They discussed current barriers to movement.	

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		Obstacles to Movement Review of ISPs for Individuals #26, #59, #63, #77, #84, #85, #88, and #139, and for Individual #61 (who had stated an interest in moving) showed the following: • No obstacles to movement were identified for four individuals, three of whom were referred for movement. • The only obstacle identified for one individual was LAR preference; no strategy was listed to address this. • For Individual #85, LAR preference was listed as an obstacle. Medical issues were also listed as an obstacle, although the medical section describing support needs stated that there were no medical obstacles. Medical treatment was being provided at the Facility, but no strategies to address LAR preference were listed. • For Individual #61, family preference and challenging behavior were listed as obstacles. Family preference was to be addressed through tours of community group homes. Challenging behaviors were addressed at the Facility through a PBSP and psychiatric services. • Medical issues and a recent increase in psychiatric issues led to an IDT decision that the most appropriate current setting was RGSC. Although this may be an appropriate decision, the Monitoring Team had a concern that the ISP reported that the nurse stated she was not sure the same medical care could be provided in group homes, but there was no plan to explore the availability of necessary medical support. • Lack of legal residency (and therefore inability to access funding) was an obstacle for one individual; the individual's family was reportedly working on application for residency. This information indicated significant progress by the Facility in identifying individuals for whom supports might be provided in a more integrated environment and in recommending these individuals be referred for community services; at the next compliance visit, the Monitoring Team will review whether providers could be found to provide the needed supports, or whether those support needs that cannot be me will be identified as obstacles. The Monitoring Team notes that the APC reported that she now attends the Living Options Discussions of ISP meetings; she was present at the ISP annual planning meeting observed. This provides an excellent opportunity for education of the IDT about what supports may be available in more integrated settings and about what information on supports is needed by providers. The Monitoring Team cautions that the development and documentation of needed supports is a role for the IDT; the APC can and should assist but should not be expected to interpret the list of support needs from the IDT	

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		discussion.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	Provision of Adequate Education About Available Community Placements to Individuals and Their Families or Guardians to Enable Them to Make Informed Choices. In December 2011, the parties met and agreed to a set of criteria for evaluation of Provision T1b2. The Monitoring Team had the following findings for each of the criteria: An individualized plan for each individual (e.g., in the annual ISP: • Measurable, and provides for the team's follow-up to determine the individual's reaction to the activities offered • Includes the individual's LAR and family, as appropriate • Indicates if the previous year's individualized plan was completed. The most challenging area with regard to education of individuals and families is individualizing this process, and documenting that individuals and their guardians are making informed decisions. In reviewing nine recently completed ISPs, four individuals (44%) had been referred for placement, and one was in process of application for legal residency. For the remaining four, the only approach referenced was community tours (including available family members). Although those tours are one aspect of a potentially effective educational approach, other approaches might be useful for specific individuals. There was no documentation of completion of plans from the prior year or their effectiveness. An annual provider fair that includes: • Outcomes/measures are determined and data collected, including o Attendance (individuals, families, staff, providers) o Satisfaction and recommendations from all participants • Effects are evaluated and changes made for future fairs The Facility held a provider fair 12/1/11. Sign-in Sheets documented attendance by 37 individuals (53% of the Facility population, three families, and 19 staff. Regular SSLC meeting with local MRAs: The Facility provided a Sign-in Sheet and materials used for training of RGSC staff by Tropical Texas MRA in November 2011. Sign-in Sheets documented attendance by 73 staff. Per materials provided, the training included information on the Home and Community-Based Services program, a list of services that can be funded, and the information needed for referral.	Noncompliance

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		Although there was no documentation or report of other meetings with the MRA, ISP documentation showed that a representative of the MRA attends each ISP annual planning meeting. <u>Education about community options that ensures:</u> • Outcomes/measures are determined and data collected on, for example: o Number of individuals and families/LARs who agree to take new or additional actions regarding exploring community options. o Number of individuals and families/LARs who refuse to participate in the CLOIP process. • Effects are evaluated and changes made for future educational activities The only education process, other than the provider fair, was tours of community settings. The APC had developed a photo album of community group homes, but no information was provided on how often this was used. The presence of MRA staff at each ISP gives an opportunity for education, and the ISPs routinely documented that the MRA staff provided CLOIP information to individuals, families, and LARs; however, as documented in the ISPs, some individuals did not respond to this information (and it is likely any written information would not be as meaningful as other types of education, including tours). The Facility should gather information on the educational activities being explored by other state centers. <u>Tours of community providers in which:</u> • All individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours). • Places chosen to visit are based on individual's specific preferences, needs, etc. • Are tours are for individuals or 2-4 people, not larger groups? • Individual's response to the tour is assessed. The Facility had begun a process to conduct tours in an organized manner that included use of a questionnaire to be completed by staff who accompany individuals on the tours. The questionnaire asks about services provided, adaptive equipment, community outings, availability of money, and staff training on medical and behavioral needs. This provides information that staff can use in assisting individuals and LARs in making decisions. The questionnaire did not ask about the individual's response to the tour. The Facility provided the Monitoring Team with copies of this information for two tours.	

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		Per the documentation provided, tours were conducted for individuals, not for large groups. The Facility did not provide data on the number of tours, the number of individuals who have toured, or the number of individuals who choose to move to settings where they have toured. <u>Opportunities are provided to visit friends who live in the community:</u> The Facility did not provide any information to the Monitoring Team about such visits, and the Monitoring Team did not become aware of any. <u>Education may be provided at:</u> • Self-advocacy meetings • House meetings for the individuals • Family association meetings, or • Other locations as determined appropriate The Monitoring Team reviewed minutes of the Advocates (self-advocacy council) meetings and attended the meeting held during the compliance visit. Although minutes did not include documentation of discussion about where to live, there was discussion during the observed meeting. No information was provided documenting other educational activities for the family association or at other meetings. <u>A plan for staff to learn more about community options that includes:</u> • management staff • clinical staff • direct support professionals The training by the MRA and the community tours provided opportunities for staff to learn about community options. The participation of the MRA and the APC at ISP annual planning meetings also provides that opportunity to discuss the supports that are available. There was no other organized process to provide learning opportunities. <u>Individuals and families who are reluctant have opportunities to learn about success stories:</u> • As appropriate, families/LARs who have experienced a successful transition are paired with families/LARs who are reluctant; • Newsletter articles or presentations by individuals or families happy with	

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		transition The Facility had not yet implemented these types of actions.	
	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.	<u>Assessment Practices Pursuant to Transition and Discharge Policies and Procedures</u> The Facility reported that the assessment occurs during the ISP annual planning meeting. And that there is no formal assessment process other than discussion of the assessments available from clinicians. In the Self-Assessment, the activity engaged in to self-assess was to "Attend annual ISPs." The ISP format began with a discussion of preferences, followed by a discussion of the Optimistic Living Vision. The discussion of preferences, as documented in ISPs and observed during the visit, did not include discussion of the types of settings an individual would prefer to live and work in, nor of the types of experiences an individual would enjoy that might affect the choice of such settings (except for relationships with families and interest in community outings). Furthermore, assessments by clinicians did not routinely include determination of most integrated appropriate setting nor indicate how the information in assessments might lead to a decision on type of setting; some assessments included supports needed, and the ability to provide those supports might differ across settings. <u>Percentage of Individuals Assessed as Required</u> Although the Facility stated that 100% of individuals had been assessed, as this was done annually at the ISP planning meeting, the Monitoring Team finds that the ISP meeting included discussion and an IDT decision (or, if the LAR objected, no further IDT decision), these were not substantive and structured assessments. To meet substantial compliance with this provision item, the facility will need to show that: • Professionals provided their determination regarding the appropriateness of referral for community placement in their annual assessments (as noted above, this was not yet occurring for all professionals) • The determinations of professionals were discussed at the annual ISP meeting, including a verbal statement by each professional member of the IDT during the meeting (this was not evident in the ISP meeting observed) • Living options for the individual were thoroughly discussed during the annual ISP meeting (this was somewhat evident) • There was documentation in the written ISP regarding the joint recommendation of the professionals on the team regarding the most integrated setting for the individual, as well as the decision regarding referral of the entire	Noncompliance

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		team, including the individual and LAR (this was generally evident although not clearly and specifically stated). The Monitoring Team noted a significant change in the outcomes of the discussion/assessment since the last compliance visit. At that time, the most integrated appropriate setting for nearly all individuals was found to be RGSC. Since that visit, for most individuals either the most integrated setting appropriate had been determined to be in a community setting, or further exploration through tours was indicated.	
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:	<u>CLDP Policy and process</u> The DADS and Facility Most Integrated Settings policies govern the development and implementation of CLDPs. As noted in Provision T1a above, the DADS policy on most integrated setting practices was being revised. This included development of a new CLDP document format, and the process for managing the CLDP. RGSC began development of the CLDP at the time the IDT decided to refer an individual for movement, ordinarily at the annual ISP planning meeting. The APC gathered the information on supports presented at the meeting and requested the assessments from which she would further develop the list of supports. The Monitoring Team expressed to the APC the concern that this should be the role of the IDT, with the APC facilitating and coordinating it; she should not interpret the supports needed but should ensure the IDT does a thorough review and listing, and clearly describes the supports needed. In fact, SOP 200 01 follows requirement of DADS Policy 018 in requiring that "the PST, in coordination with the MRA, shall develop and implement a community living discharge plan(.)" As noted in the report from the last compliance visit, "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 reiterates this recommendation from that visit. <u>Timeliness of Development and Implementation of CLDP</u> The Monitoring Team reviewed the CLDPs for Individuals #107 and #145 and the draft CLDPs for Individuals #13, #80, and #121. The Monitoring Team considered two of five CLDPs (40%) to have been developed timely. • The CLDP for Individual #107 was dated 15 days prior to the date of transition; the individual returned to the family home, so the information on support needs was not required for identifying a home. Although having a list of supports would be helpful in identifying services needed, the individual's family was well	Noncompliance

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		aware of support needs even prior to the beginning of the referral process more than four months prior to the move. • Individual #145 also moved to the family home. The CLDP was completed five weeks prior to the move. • Individuals #13, #80, and #121 were scheduled to move the week after this compliance visit, and a pre-move visit to their planned home was held during the compliance visit. Although a list of essential and nonessential supports had been drafted, not all assessments had yet been provided, the CLDP had not been finalized, and there had not been a final pre-move meeting between the Facility and the new provider. An email from the APC stated that these CLDPs were not yet completed, but work began on them at the time of referral, and completion was pending assessments. Although a CLDP will not be finalized until an individual is accepted and agrees to service in a 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. A final CLDP must be completed before the pre-move site visit to ensure all essential supports are in place at that time. <u>Timeliness of Referral and Movement</u> The Facility provided a list of individuals referred for community placement that included dates referred and moved. Of the three individuals who moved, two (67%) moved within 180 days of referral. The other (Individual #145) had visited three provider agencies and had, according to the CLDP, been refused service by all; instead, this individual moved to the family home. Of the 15 individuals on the list for referral, seven (47%) had been on the list for over 180 days. Of that group, three individuals were scheduled to move the week following this compliance visit. <u>Development of CLDP in coordination with the MRA</u> Each of the two completed CLDPs had signature of the MRA. No other information was provided that documented coordination with the MRA in the process of developing the CLDP. However, it was clear from discussion of the review meeting for Individual #145, who had been placed in psychiatric hospitalization, that coordination had occurred both before the individual moved and afterward.	
	1. Specify the actions that need to be taken by the Facility,	<u>Identification of Essential and Non-Essential Supports</u> The CLDP process is a continuation of the Facility's responsibility to assess the needs of	Noncompliance

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	including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	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 supports and preferences identified in the ISP. IDTs did not demonstrate proficiency in overall needs assessment, the interdisciplinary process necessary to integrate the assessment findings into a comprehensive support plan, or the identification during the ISP planning meeting of the supports and services needed and desired in a community setting. The Monitoring Team reviewed two completed CLDPs for individuals who had moved and three draft CLDPs for individuals who were scheduled to move the week after the compliance visit. • Individual #145: This individual had moved to his family home a few weeks prior to the compliance visit. Providers of group home services had refused to serve him because of his aggressive behaviors, because of his behavior during a tour, or because of lack of a home for him. Following his move home, funding issues led to a lapse in his psychotropic medication; the Facility reported having requested permission to provide him with medication but reportedly being denied, and there was a delay in approval for other funding for services. Following the lapse in medication, the individual became increasingly aggressive and was admitted to a psychiatric hospitalization. During the hospitalization, medications were changed. A review meeting was held at the Facility during the compliance visit to discuss whether to re-admit the individual to the Facility or to provide other resources and assistance so the individual could leave the current psychiatric hospitalization and eventually return home. The MRA stated during the meeting that they would have provided the medication. Apparently, there was a significant set of miscommunications among the family, Facility, MRA, and possibly agency that approves the funding. During the meeting, the Facility stated the community psychiatrist had changed the medications even though RGSC had given a recommendation not to change medications; however, the CLDP not only did not address the issue of changing medications, it also did not include supports needs such as follow-up with a psychiatrist and ensuring funding was in place to permit filling the individual's prescriptions (which included seizure medications as well as psychotropic medications). Review of the CLDP and supporting ISP and assessments identified the following: o The ISP identified challenging behavior of aggression that had led to use of restraint; the individual's services included a PBSP; the PBSP listed a seizure medication used for psychotropic purpose. The seizure medication was also listed on the annual medical assessment but the purpose was not described. The Facility did not provide a psychiatric assessment in the packet of CLDP assessments. The CLDP, however, stated that the seizure medication was discontinued due to a possible	

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		side effect, and two other psychotropic medications were initiated. Nowhere did the CLDP provide instructions that the psychotropic medications were not to be changed, as reported by the Facility during the review meeting. Furthermore, the CLDP identified as non-essential supports follow-up with a neurologist and a physician for GI issues but did not identify a support need for follow-up with a psychiatrist (although a psychiatrist's name and phone number were listed under "Community Living Data") or for involvement of a psychologist or behavior analyst to assist the family with behavioral intervention. Also, there was no support listed for training the staff of the day program provider on the PBSP. Given the individual's identified aggression, these were serious omissions of important supports that might have prevented the adverse outcome of psychiatric hospitalization. • Individual #107: This individual, who also moved back to the family home and attended a day program, also had a PBSP for aggression and was prescribed a psychotropic medication. In contrast to the above individual's CLDP, this CLDP included as essential supports training for day program staff on the PBSP, and to continue with a monthly psychiatry appointment for three months as a non-essential support. Moreover, the IDT identified a concern during the period between the original referral to move home and the actual move—the concern was that there would be nobody to assist and supervise the individual if the father had a severe injury or sudden illness. As a result of identifying this concern, the IDT established an ISP goal to learn to dial 911. This CLDP provided an example of identifying necessary supports and including them in the list of supports needed, as well as of using the ISP planning process to address an issue that could affect the success of movement to a specific chosen setting (rather than focusing only on goals relevant within the facility or considered important in generic "community living"). • Individuals #13, #80, and #121: Planning had been in process for an extended time to permit these three individuals to move into the same home at the same time, which was considered essential to their successful transition. CLDPs were not complete, although the move was to take place in the week following this compliance visit, and the APC conducted the pre-move site visit during this compliance visit. For all three individuals, essential supports (the ones that would be reviewed during the pre-move site visit) had been entered into the CLDP (although some assessments were still pending). This was particularly a concern for Individual #80, who had complex medical conditions, and for whom updated assessments might indicate additional essential supports. Nevertheless, the CLDP for Individual #80 included a wide array of support needs. Following are comments about the supports listed: o An essential support was a high back chair with armrests. There was no	

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		specified support for such a chair at the dining table, and this was not noted by the APC during the pre-move site visit until pointed out by the Monitoring Team. The individual would have been at the same risk for fall at the dining table as in the living room, and the chairs at the dining table were low-back, did not have arm rests, and were very light weight. The APC added that as an essential support when it was pointed out. o Need for bowel monitoring due to "severe history of constipation" was listed as a non-essential support. Severe constipation could lead to hospitalization and severe health conditions if it were not monitored for 90 days. o The evidence for presence of a hospital bed was listed in the CLDP as "Copies of paperwork." Fortunately, the APC instead actually did a visual check to ensure the bed was present and in good condition. o A positive finding was that essential supports included training provider staff on the individual's diet, behavior support plan, communication dictionary, and lift vests. Evidence, however, was "signature sheets"; there was no requirement for a competency check. o Several members of the Monitoring Team reviewed this individual's active record. Medical assessments and consultations indicated the potential for a severe condition that could lead to serious consequences from a fall or the individual's self-injurious behaviors. Although relevant supports were listed in the CLDP, the Monitoring Team was concerned that the CLDP did not indicate and the provider might not have been made fully aware of the significance of this condition and the need for supports related to this condition. o The CLDP included an extensive review and recommendations for psychiatric care and psychotropic medication management. However, there was no support listed for follow up by a psychiatrist or for discussion by the Facility psychiatrist in passing this case on to a community psychiatrist. <u>Identification of Actions Needed for Transition</u> The CLDPs did not include a listing of tasks and responsibilities for carrying out transition activities other than the lists of supports and items to be provided or done on the day of transition. As a result, important activities such as ensuring funding is established may fall through the cracks. An example occurred with Individual #145. It appeared that nobody took responsibility to assist the individual's mother and ensure funding was in place, nor to ensure that medications could be provided. There was no plan for what to do if the 30-day supply provided by RGSC ran out before the individual's community Medicaid took effect (which occurred, and which led to psychiatric hospitalization). The Monitoring Team suggested this might be a place for an agreement	

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		to be forged that would ensure the provider as willing to cover the medications if such a lapse were to occur. As another example, staff at some facilities have indicated at times that community providers do not notify them of certain incidents that may indicate an adjustment concern for an individual, particularly one that might benefit from technical assistance from the individual's IDT. The agreements section may be used to specify circumstances in which the provider agency will notify the Facility of such concerns. The Monitoring Team recommends that the Agreements section of the CLDP may be used more creatively to ensure adequate supports, services, and protections are provided and maintained.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	<u>Responsible staff identified for needed actions:</u> Zero of two completed CLDPs (0%) consistently identified Facility staff responsible for providing or checking supports. • For Individual #107, responsibility for supports was identified as "QDDP" or "Medical" with no specific staff assigned. • For Individual #145, the responsible staff for all essential supports was the QDDP, who was listed by name. The responsible person for all non-essential supports was the individual's mother. No Facility staff was named to provide assistance or to ensure supports were provided (or to assist the APC—who did the post-move monitoring—in responding quickly to put supports in place as needed). In this case, there was not Facility staff assigned to ensure application and eligibility for funding occurred, resulting in a lapse of funding for psychotropic medication. For three of three draft CLDPs (100%), either a Facility staff or a staff of the provider agency was listed by name as responsible. Still, no Facility staff was named to assist with or ensure actions occurred, which might help to ensure these actions occur as needed, not only at the time of post-move monitoring. Timelines and due dates were listed on none of the CLDPs (0%).	Noncompliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	<u>Review of CLDP with Individual and, as appropriate, the LAR:</u> For the two individuals who returned home, the LARs were involved throughout the process of referral and planning of the CLDP; the CLDP documented involvement, and observation of the review meeting for Individual #145 provided additional confirmation. For the three individuals scheduled to move, no LAR or family was available; per report of the Facility both at the current and the prior compliance visit, an advocacy organization was involved throughout the process of referral and planning; signatures were not yet available, and the draft CLDP did not document the involvement.	Substantial Compliance

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T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	Timeliness of Assessments: During the site visit, the APC informed the Monitoring Team that the CLDPs for three individuals scheduled to move in the following week remained in draft form because not all required assessments had been provided. Assessments provided by the Facility as attachments to the CLDP included both timely assessments and others completed more than 45 days prior to the date of move. Each CLDP included summaries of assessments and recommendations; based on those summaries, the Facility had not attached for Monitoring Team review all assessments completed. • For Individual #107, the summary identified five assessments, three of which (60%) were within 45 days. In addition, a Comprehensive Nursing Assessment completed within 45 days was attached but not listed in the summary. • For Individual #145, the summary identified five assessments, two of which (40%) were within 45 days. • Although both individuals had challenging behaviors and psychiatric diagnoses for which medication was prescribed, neither included a psychiatric assessment in the summary or attachments provided to the Monitoring Team. Adequacy and Comprehensiveness of Assessments: Issues raised in other sections of this report document need for improvement in assessments. As a result, the Facility continues to need to improve identification of supports and services needed both during an individual's residence at the Facility and as part of transition to a more integrated setting. • As reported in Provision P1 for Individual #80, there was not a comprehensive PT assessment conducted recently that accurately reflects his current status and provides clear instructions for staff to follow to ensure safety. This led to a concern by the Monitoring Team about ensuring supports are in place in prior to discharge. Due to identified cervical stenosis, the risk of serious injury should the individual fall is extremely high. It is the concern of the Monitoring Team that lack of comprehensive assessment and planning prior to discharge will result in the individual being placed at unnecessary risk.	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	MRA Continuity of Care Process: The lack of follow-through resulting in a lapse in availability of psychotropic medication for Individual #145 brought into question continuity of care. This was confirmed during the review meeting, when the MRA representative stated that the MRA would have ensured the medication was available. There appeared to be a lack of consistent understanding among the Facility, MRA, and family as to what had actually happened, as well as a lack of follow-through and transfer of responsibility that might have ensured all	Noncompliance

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	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.	parties worked together to prevent the adverse outcome. <u>Pre-Move Site Visit Completed by Facility:</u> The Monitoring Team observed a pre-move site visit completed by the APC of the home to which three individuals were scheduled to move. The APC reviewed each item listed as an essential support and either visually verified its presence or stated which Facility staff would provide it on the day of the move. The process of review was adequate, but the listing of supports on the CLDP was not clear enough to ensure appropriate review. For example, one support for Individual #80 was a high back chair with armrests; per report of the APC, the individual sits down heavily on the chair and can knock it over, and the armrests are a protection if a seizure occurs. The APC checked to ensure such a chair was available in the living room but did not observe that the dining room chairs were low-backed, lightweight, and did not have armrests. The APC reported that she did a pre-move site visit to each home prior to the move to ensure essential supports are in place. She stated she usually waits till the 7-day post-move monitoring visit to look at non-essential supports.	
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.	The Facility reported in its Self-Assessment that it monitors CLDPs to ensure that we implements (sic) the portions of the plans for which we are responsible." This would be only one aspect of quality of this process and of the CLDPs themselves, and the Facility needs to view the whole process and select aspects to be monitored and tracked for quality improvement purposes. The Self-Assessment stated "No monitoring data is available."	Noncompliance
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take	Activities at the Facility and State levels demonstrated progress toward compliance with this provision. RGSC provided an annual report on obstacles to transition using data as of 8/31/11. This report included categorization of obstacles as established by DADS. Data were provided for five fiscal years (fy2007-2011) that listed numbers of community referrals, rescinded referrals, community transitions, community transition returns, and census. <u>Obstacle Information Gathered:</u> The Facility was beginning to gather and report data on obstacles, but the data were limited. In the report to DADS, the Facility reported there were 71 individuals at RGSC ICF-DD services, and that 11 of these people were recommended for community	Noncompliance

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	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.	placement. However, the tables that listed reasons individuals who prefer to reside in the community but were not referred for movement included only 20 people; the table listing obstacles to transition listed 20 (but, based on the descriptions of categories, these appear to be the same individuals); and no other obstacles were listed. The report stated (Item #10 under Center Strategies and Actions to Overcome or Reduce Obstacles) that RGSC had not collected data consistent with the DADS Most Integrated Setting policy and had developed and implemented a data collection process as outlined in policy; this issue was not identified in the Facility Self-Assessment. The Facility provided no additional information to the Monitoring Team that listed obstacles to movement. The report stated that the Facility had taken steps to address the obstacles listed. These included scheduling tours of community group homes, seeking resources for legal assistance to families seeking residency for the individuals who are not legal residents so services can be funded, and meetings between the MRA and LARs who state they will not approve transfer to discuss living options. <u>Appropriate Steps Taken by DADS to Overcome or Reduce Identified Obstacles</u> DADS took steps to overcome or reduce obstacles. ▪ DADS created a report summarizing obstacles across the state, and included the Facility's report as an addendum/attachment to the report. The statewide report was dated October 2011. ▪ The statewide report listed the 13 obstacle areas used in FY11. DADS will be improving the way it categorizes and collects (and the way it has the Facilities collect) data regarding obstacles. ▪ DADS indicated actions that it would take to overcome or reduce these obstacles: o Eleven numbered items were listed. Five were related to the IDT process and upcoming changes to this process, three were related to working with local authorities and local agencies, two were related to improving provider capacity and competence, and two were related to funding initiatives regarding slot availability and the new community living specialist positions. In general, these were descriptions of the early steps of activities related to addressing obstacles to each individual living in the most integrated setting. o DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS).	
T1h	Commencing six months from the Effective Date and at six-month	<u>Timeliness of Report</u> RGSC issued a Community Placement Report covering meeting dates from 9/1/10-	Substantial Compliance

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	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.	2/14/12 but listing individuals' meeting dates from 5/5/11-1/12/12. This report included categories of individuals on the current referral list, those individuals who prefer community but were not referred for LAR Choice or for other reasons, and of those individuals whose LARs prefer community but the individual has not been referred. It also listed community placements and rescinded referrals. Required Reporting Categories--The report provided the following data: • No community placements (but this was not consistent with three placements since the last compliance visit) • Sixteen current referrals (this list included one person in addition to the list of referrals provided in the document request) • No rescinded referrals • No individuals who preferred community, not referred-LAR choice • Two individuals who preferred community, not referred-other reason (but this did not include names of two individuals identified by the Monitoring Team as stating a desire to move to community) • No individual for whom the LAR prefers community, not referred. The Monitoring Panel asked that a final category be added that includes a list of names of individuals who would be referred by the team except for the objection of the LAR whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. As noted above with regard to provision T.1.a of the Settlement Agreement, professionals on individuals' teams need to make independent recommendations regarding the appropriateness of an individual for community placement. The State indicated that its data system did not include this information, but it was working toward being able to produce the data the Monitoring Panel requested.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move	The last compliance visit found this provision to be in substantial compliance. At this visit, this provision is not found to be in substantial compliance for the following reasons: • The Facility did not provide documentation of seven-day and 45-day PMM visits for Individual #39. • Only living settings (homes) were visited, not day programs.	Noncompliance

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	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.	• Follow-up including possible revision to the CLDP should be done when an change occurs in a significant service or when an individual refuses to participate in a planned service; this was not done. <u>Staffing</u> Alma Ortiz, Admission/Placement Coordinator, conducted post-move monitoring. <u>Timeliness of Post-Move Monitoring Visits</u> Post-Move Monitoring documentation was reviewed for three individuals. Information on visits provided by RGSC included only a 90-day PMM visit for Individual #39, which would not meet the requirements for a seven-day and 45-day visit. The information documented visits for Individual #107 appropriately for the first two visits due but not for the 90-day visit.. The information documented the seven-day visit to Individual #145; by the time the 45-day visit was due, the individual had been admitted to a psychiatric hospitalization, and a review meeting to discuss options was held during the compliance visit. <u>Use of Standard Assessment Tool</u> In each case, the PMM visits were documented using the Post-Move Monitoring Checklist. This checklist included a list of special equipment that the Facility should have provided, lists of essential and non-essential supports and whether they were in place, a place to document comments as well as actions to be taken for any support not in place, a list of general questions and items to check indicating which are relevant to the individual and the Yes/No answers to the questions, a place to document actions to be taken related to the answers to the questions, a place to document miscellaneous actions, and a place to document specific actions all parties will take if outcomes and criteria are not met. This tool appeared useful and comprehensive. For each of the visits, the checklist documented only that APC visited the Living Environment although the APC documented training of day habilitation staff by RGSC staff for Individual #107. The visits should include both living setting and other program settings. It should be noted that Individual #107 stated that she does not want to attend the day program but instead attends a senior program with her father; this was reported to be acceptable also to the father. The CLDP should be updated to reflect this, and any supports needed for the senior program, if any, should be identified. Also, Individual #145 had refused to attend the day program, so a visit to that program would not have been productive. <u>Assessment of Presence of Supports Called for in CLDP</u> PMM checklist documentation indicated that all supports were reviewed appropriately. Each support due by the time of the visit was verified. In most cases, the means of	

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		verification was clearly stated and was appropriate; in the case of Individual #145, some items were noted as "kept in (the) bathroom" or ""in the kitchen cabinets" but it was not clearly stated whether the APC visually checked those or learned that by report. In each case, the APC provided a statement of the process and general impression of the visit, and of any supports that had not been provided. <u>Facility's Efforts to Ensure Supports are Implemented</u> For Individual #107, the APC documented actions to be taken regarding missed appointments and follow up to ensure those actions had occurred. This follow up involved the provider agency, the family, and RGSC staff. There was no revision to the CLDP or planned follow-up regarding the individual's preference to attend the senior center. For Individual #145, there was no follow-up to either revise the CLDP or to identify a process to engage the individual in the planned day program. The PMM should have engaged the IDT in review of this concern and either planning of alternative service or assistance to the family and day program provider to increase the individual's participation.	
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.	<u>Observation of Post-Move Monitoring Visit</u> No Post-Move Monitoring Visit was scheduled during this compliance visit. Therefore, this provision is not rated.	Not Rated
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum	This provision does not receive a rating for this Facility.	

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	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-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	No individuals were discharged pursuant to an alternative discharge.	Not Rated

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	pursuant to a court order vacating the commitment order.		

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

1. Establish a consistent process, provide training, and monitor to ensure each professional provides in the annual assessment a determination of the most integrated appropriate setting for each individual. (Provision T1b1)
2. IDTs 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. (Provision T1b2)
3. Consider developing 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 T1b3)
4. CLDPs should identify the responsibility of the provider agency staff to actually implement certain action steps, but should also assign responsibility to Facility staff by name to ensure that all required activities are completed, even if a provider or MRA staff has primary responsibility for the activity. The implementation of the Facility Pre-Move Site Visit may provide an avenue for designating the responsibility of Facility staff, as the APC could take responsibility for ensuring the completion of essential supports and plans for non-essential supports at the time of the Pre-Move Site Visit. (Provision T1c2)
5. Develop a CLDP quality assurance process to include specific requirements and criteria for ensuring assessments and plans are adequate and are timely. (Provisions T1d and T1f)

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-assessment CV 4 dated 2/13/12 2. RGSC Action Plans CV 4-1 dated 2/9/12 3. RGSC Entrance Presentation handout 4. Section U Presentation Book 5. DADS Draft Policy and final Policy19 Guardianship (effective 3/7/12) 6. DADS Draft Policy Affirming and Protecting Rights (undated) 7. RCGS SOP ICF-MR 200 04 revised April 2011 8. Texas Probate Code Chapter XIII Guardianship 9. Priority tool used for prioritizing need for guardianship 10. Training roster for Need for Guardianship Ranking training session of 1/27/12 11. Need for Guardianship Record of 1/30/12 12. List of new guardianships obtained 13. Contact Log for Guardianships 2/18/11-2/2/12 14. PSPs/ISPs for Individuals #26, #59, #63, #77, #84, #85, #88, and #139 15. PSPs/ISPs and associated assessments for Individuals #27, #55 and #97 16. Letter of 1/10/12 to "All RGSC Family Members" 17. Minutes of Advocates (Self-Advocacy) meetings of 8/23/11, 9/20/11, 11/22/11, 12/20/11, and 1/24/12 **People Interviewed:** 1. Liza Pena, current Human Rights Officer (HRO), and Alicia Alaniz, HRO who will be responsible for the ICF/MR program **Meeting Attended/Observations:** 1. ISP annual planning meeting for Individual #97 2. RGSC Advocates (Self Advocacy council) meeting of 2/28/12
	Facility Self-Assessment: The Facility reported that it complies with Provision U1 but not Provision U2. The Monitoring Team did not find compliance with either provision. Regarding Provision U1, the Monitoring Team agrees that the guardianship was reviewed and all individuals were ranked for need for guardianship. However, there is a requirement in the Settlement Agreement that this review prioritize, in part, based on the individuals' functional capacity to make determinations regarding health or welfare; the Facility had no formal process to assess functional capacity to make a decision, nor did DADS policy provide guidance on this issue, nor was there evidence in ISPs that IDTs discussed need for guardianship in relation to the individual's ability to make decisions. These issues need to be addressed in the self-assessment
	Summary of Monitor's Assessment:

	The Facility continued its efforts to rate and prioritize the need for guardianship, as well as very creative efforts to identify resources to encourage families and advocates to become guardians. Neither the Facility nor draft DADS policy provided guidance about assessing functional capacity to make decisions or to identify the areas in which each individual is able to make informed decisions as well as those areas in which he/she cannot make such decisions. Final DADS policy was not implemented at the time of the compliance visit. The Facility used criteria in the draft DADS policy to prioritize need for guardianship. The HRO attends every annual ISP meeting to discuss guardianship and to be a resource for explanation to families. There was no evidence in ISPs (0%) for individuals without guardians that IDTs were discussing the need for guardianship in relation to the individual's ability to make decisions or give informed consent, although discussion of rights was documented with some individuals. The regular participation of the HRO in ISP planning meetings is commendable but should be supplemented by further training of IDT members so they can make appropriate determinations of need for guardianship. To ensure enhanced level of supervision (LOS) does not occur without HRC review, the HRO began to get a table each day that lists LOS. This table was also provided to QDDPs, supervisors, and DCPs so that they are all aware of current enhanced LOS assignments. Furthermore, HROs reported they attend Incident Management meetings, where enhanced LOS is to be reported, so they can check documentation. Finally, HROs reported they do rounds to the living units daily, and staff can inform them of need to implement or discontinue enhanced LOS. This was an appropriate and valuable response to correct an issue of concern identified by the Facility. The Facility was making efforts to obtain guardianship and had some success in getting guardianships renewed, but not yet in obtaining new guardians. The Facility had taken creative action to recruit an attorney and judge to provide pro bono assistance and to reduce the cost to file guardianship applications, and had sent information out to families and advocates to inform them; the Facility reported several families were in process of using this resource to apply for guardianship.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision	Status of Policies and Procedures: Statewide policies and procedures remained in draft form, according to the HRO. The statewide drafts previously made available to the Monitoring Team for review included policies on Guardianship, Advocate, Self-Advocacy and Affirming and Protecting Rights. At the time of the compliance visit, the Facility did not know when these policies would be finalized, and the Facility was awaiting final versions before localizing the requirements. No changes had been made to Facility policies in this area in the meantime.. The Guardianship policy draft provides guidance	Noncompliance

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	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.	on the process of IDT planning for guardianship for individuals who are "unable to give legally adequate consent" and do not have a Legally Authorized Representative {LAR), prioritizing guardianship needs, and providing education about guardianship. However, the policy draft does not give guidance on how to determine that an individual without an LAR is unable to give legally adequate consent. RGSC Policy ICF/MR 200 04 guides the process of assessing and reviewing need for guardianship, providing education to family members, and reminding guardians to process paperwork to prevent expiration but does not provide criteria for rating need or for assessing ability to give consent. Per interview with the HROs, the Facility is waiting for a final policy from DADS and will then revise the local policy. Following the compliance visit, DADS finalized the Guardianship policy and distributed it, effective 3/7/12. As was the case for the draft policy, the final policy provides guidance on the process of IDT planning for guardianship, prioritizing guardianship needs, and providing education about guardianship but does not give guidance on how to determine that an individual without an LAR is unable to give legally adequate consent. The final policy included the same priority level criteria for seeking guardianship as in the draft. However, procedures listed in Appendix A provide a different set of criteria. The Monitoring Team recommends DADS review these instructions for prioritization in the Guardianship Policy on page 4 under Guardianship List and in number 5 of Exhibit A to ensure a consistent process and reconcile the differences in guidance to the facilities. <u>Maintenance of Prioritized List:</u> The Facility maintained a list of individuals in need of guardianship, organized by area of residence. On 1/27/12, HROs trained a committee of QDDPs, clinicians, and direct service supervisors on rating of need for guardianship. Information on training for ranking need for guardianship was minimal. No curriculum was provided other than the criteria for level of need. Per interview, training consisted primarily of presenting the criteria to trainees and then jointly ranking individuals. Although this is an important component of competency-based training, it would be useful at a minimum to have the criteria for levels presented followed by ranking of a sample of individuals independently by trainees to verify competence. In addition to ensuring the joint ranking of priority for guardianship is based on competent review of criteria, ensuring each individual is competent could influence discussion during ISP planning meetings throughout the year. On 1/30/12, this committee jointly rated priorities for guardianship for each individual residing in the Facility. Ratings were based on a set of criteria derived from the draft DADS Guardianship Policy that identified four levels of need—high, medium, low, and N/A—as quoted: 1. *Those individuals who have been determined to be least able to express their own wishes or make determinations regarding their health or welfare.*	

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		2. Those individuals with comparatively frequent need for decisions requiring consent. *3. Those individuals with comparatively most restrictive programming, such as, receiving psychotropic medications.* *4. Those individuals with potential guardianship resources.* *Priority 1=individuals meeting three out of four of the above mentioned factors.* *Priority II-individuals meeting two out of four of the above mentioned factors.* *Priority III—individuals meeting one out of four of the above mentioned factors.* *Non-Priority=individuals have a guardian.* The above criteria and priorities I-III matched the criteria and priorities in the draft DADS policy. The new semiannual ranking resulted in 35 people being rated at Priority I, compared to eight individuals being rated at High need at the last semiannual ranking. Thirteen individuals were ranked as Priority II, compared to eight people rated at Medium need at the last ranking. Two people were ranked as Priority III, compared to 36 people ranked as Low need at the last ranking. Twenty-one individuals were rated as Non-Priority, compared to 22 rated as N/A at the last ranking. This is a significant increase in rating of individuals having a high need for guardianship. It is not clear whether the difference resulted from the criteria used or from a change in the viewpoint of the staff who were doing the rating. The ranking sheet identified for each individual which criteria were met but did not give any additional information.. One possible explanation is that the prior criteria for Priority I no longer included a judgment that the individual be non-verbal and unable to communicate wants or needs or could not advocate for him or herself, as the prior criteria had, but instead stated the individual was "least able to express their own wishes or make determinations regarding their health or welfare." <u>Assessment of Functional Capacity to Render a Decision:</u> The Facility reported the IDTs did not use 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 Texas Guardianship Statute in Sec. 693(b) recognized guardianship as a restrictive procedure that required due process. The statute also offered limited guardianship as a less restrictive option to full guardianship. Therefore, it is important that assessments of an individual's capacity to provide informed consent detail the areas in which he/she is able to make informed decisions as well as those areas in which he/she cannot make such decisions. Further, it is important for such assessments to identify if there are supports or resources that could enable an individual to make informed decisions, or increase their capacity to make such decisions. Determination of the need for guardianship was done as part of the Rights Assessment	

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		within the PSP planning process. Facility SOP 200 04 requires that the QMRP and PST assess the need for guardianship at the 30-day program planning conference and review at least annually. Per report of the Human Rights Officer, IDTs had received no training about guardianship and consent (except for training the HRO reported having provided on 11/21/11 to QDDPs to discuss s part of annual rights assessments). Although the QDDPs served on the panel that established the rankings of need, the IDTs as a whole need to provide the information necessary for such decisions. The Facility should provide training not only to the panel but also to PST members who provide the information. A positive action that somewhat mitigated the need for such training was that the HROs reported that the HRO attends every annual ISP meeting to discuss guardianship and to be a resource for explanation to families. A sample of 11 ISPs was reviewed for evidence that the team had discussed the need for guardianship. Seven (64%) individuals in the sample did not have guardians. There was evidence in zero of the seven ISPs (0%) for individuals without guardians that IDTs were discussing the need for guardianship in relation to the individual's ability to make decisions or give informed consent, although discussion of rights was documented with some individuals. Further, although several ISPs included documentation of family relationships, in only two (29%) of the seven ISPs was guardianship discussed in relation to the availability of family members to provide advocacy (including one with power of attorney for medical care). The current HRO also found that enhanced Level of Supervision/1:1 supervision was occurring without HRC review, but this was no longer happening following training last July. To ensure this does not reoccur, the HRO receives a table each day that lists LOS. The table was also provided to QDDPs, supervisors, and DCPs so that they are all aware of current enhanced LOS assignments. Furthermore, HROs reported they attend Incident Management meetings, where enhanced LOS is to be reported, so they can check documentation. Finally, HROs reported they do rounds to the living units daily, and staff can inform them of need to implement or discontinue enhanced LOS. The Monitoring Team reviewed minutes of the Advocates meetings held since the last compliance visit. Minutes documented discussion at each meeting about rights, including right to work, how to work in the community, dental treatment rights, confidentiality, and "rights." There was no report of formal training on self-advocacy, and the ISPs reviewed did not include goals to improve an individual's ability to advocate for himself/herself. The Monitoring Team recommends that the Facility assist individuals to develop skills for decision-making through ISP goals and consider obtaining and implementing a formal choice-making/self-advocacy curriculum that would foster the abilities of individuals to participate in meaningful decision-making about their lives. There are many good examples of such curricula for individuals with intellectual	

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		disabilities that may be adapted for use by the Facility.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	Status of Policies and Procedures: As indicated above under Provision U1, statewide policies and procedures pertinent to Provision U2 remained in draft form at the time of the compliance visit. DADS Policy 019 Guardianship was implemented 3/7/12. Other relevant policies regarding advocacy and protecting rights remained in draft. Efforts to Obtain LARs: The Facility had obtained guardians (LARs) for five individuals since the last compliance visit. All five were renewals of guardianships for individuals whose guardianships had expired. The Facility was making efforts to obtain LARs. • One remarkable achievement was recruitment of an attorney and judge to provide pro bono assistance and to reduce the cost to file guardianship applications. The Facility then sent a letter dated January 10, 2012 "To All RGSC Family Members" stating that the attorney is willing to help families who are in need of renewing or obtaining guardianship, and providing the telephone number of the law firm (per interview, this letter had been translated into Spanish but had not yet been mailed). The HRO reported that six families were in process of application at the time of the compliance visit. • The HRO provided a copy of a log of contacts for guardianship from 2/18/11 through 2/2/12. The log recorded contacts with guardians to renew guardianships and with possible guardians for individuals who did not have and LAR, presentation at a facility Parents Meeting to provide information about guardianship, notes about guardianships that had been renewed, and efforts to recruit financial assistance for families seeking guardianship. • As noted above, the HRO made a presentation in September, 2011, to the Parents Association meeting. • The HRO reported beginning to discuss with guardians at annual ISP planning meetings about the need for alternate guardians in case the LAR is unable to continue. As stated in the Self-Assessment, the Facility did not yet comply with this provision due to the number of individuals without guardians. The Monitoring Team urges the Facility to establish a more formal process of assessing functional capacity to make decisions as part of the process of determining who needs guardianship for what areas of decision and of obtaining guardians for those areas in which they are needed. The Facility should continue its creative efforts to find resources to assist in applying for guardianship.	Noncompliance

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

1. Training on criteria for ranking priority for guardianship should include a measure of competence such as having each trained staff independently rate a sample of individuals and determine agreement with trainer ratings.
2. The State should review the instructions for prioritization in the final DADS Guardianship Policy on page 4 under Guardianship List and in number 5 of Exhibit A to ensure a consistent process and reconcile the differences in guidance to the facilities.
3. The State should provide key Facility staff with training on implementation of the finalized Guardianship policy.
4. RGSC should develop and/or revise its policies related to guardianship and informed consent to reflect the State policy.
5. Based on any additional information provided in State policy regarding prioritization for guardianship, RGSC should review the list that identifies individuals who need the support of a guardian, and re-prioritize the list, as appropriate.
6. RGSC staff should collaborate with staff from other SSLCs to identify and implement potential initiatives and resources for identifying guardians.

The following are offered as additional suggestions to the Facility:

1. The Facility should obtain and implement a formal choice-making/self-advocacy curriculum that would foster the abilities of individuals to participate in meaningful decision-making about their lives..
2. The Facility should consider additional resources regarding decisional capacity that exist nationally, and that may further inform and amplify the development of training. A sampling of such resources include::
    - *Decisions By and For People with Mental Retardation: Balancing considerations of Autonomy and Protection*, James W Ellis;
    - *Decision-Making Capacity in Adults: Its Assessment in Clinical Practice, Bellhouse,* et al;
    - *Alternatives to Guardianship* on-line training found at maine.gov/guardianship, which provides additional assessment documents; and,
    - A variety of resources found at guardianship.org

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-Assessment and Action Plan (AP) 2/13/12 2. RGSC Section V Presentation Book 3. DADS Policy 020.1 Recordkeeping Practices revised 3/5/10 4. RGSC SOP HIM 400-07 ICF Documentation Guidelines revised 10/28/11 5. RGSC SOP HIM 400 14 Filing and Purging of Information Policy/Procedure revised 1/30/12 6. RGSC SOP HIM 400-20 ICF-MR Monthly Record Review Policy/Procedure revised 11/1/11 7. Table of Contents of the ICF-M Services Standard Operation Procedures Manual 8. Settlement Agreement Provision V.4—Interview Tool for use of the Record forms completed 7/21/11 9. Share Drive assessment folder for Individual 10. Tables of Contents for Active Record (Active Record Order and Guidelines), Individual Notebook, and Master Record 11. Active Record, Individual Notebook, and Master Record for Individual #8 12. Active Record and Individual Notebook for Individual #46 13. Active Record Audit Tool for Individual #8 14. Numerous progress notes for several individuals from Clinical Work Station (CWS) 15. Active Record Audit Tools (completed by Facility) for December 2011 audits for Individuals #31, #63, #74, #76, and #139 and January 2012 audits for Individuals #21, #55, #59, #84, #87 16. Inter-rater Audit Record Tool completed by HIM for Individual #84 17. Action/Corrective Action Reporting Documents for audits of November and December 2011 18. Correction Follow-up Emails from Melissa Canales for December 2011 and January 2012 19. List of Individuals with "Date of Annual PSP" in February, 2012 20. List of Individuals Admitted to RGSC since the last compliance visit 21. December 2011 ICF Monthly Delinquent Assessment Report dated 1/3/12 22. Annual Assessments Filed within 10 Days for period of 8/1/11-1/31/12 23. Email of 3/1/12 from Rosa Sanchez to Mary Ramos re: clarification on PSP assessments tracking log and HIM audit 24. Authentication of Verbal Orders 11/1/11-1/31/12 and graph of monthly data 25. Process for Approving New/Revised Forms flowchart 26. Samples of forms going through the process of approval: Hospital Liaison Report, and Quarterly Medical Review **People Interviewed:** 1. Leticia Gonzalez, RHIT, Health Information Management (HIM) 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. QDDPs Rebecca Olivares, Laura Morales, and Karina Serratos 5. Belinda Lopez, SLP, and Jane Augustine, PT

	Meeting Attended/Observations: 1. ISP Annual Planning Meeting for Individual #97
	Facility Self-Assessment: The Facility provided two documents intended to present the status of current efforts to comply with the Settlement Agreement. The first was a Self-Assessment reflecting measures of progress. The second was the Action Plan that outlined the steps the Facility had identified as critical to satisfying the Settlement Agreement. The Facility's Self-Assessment Report included the activities the Facility engaged in to conduct the self-assessment, data to represent the results for Provisions V1 and V3, and self-ratings based on the findings. The Facility assessed that it was in substantial compliance with Provision V1 because 100% of records for individuals served included an active record established per guidelines and individual notebooks. In addition, all expectations in the Guidelines established at the Facility were in place. The Monitoring Team agreed that all individuals had an active record and individual notebook but did not agree that all requirements of DADS and Facility policy were fully in place, or that all requirements of DADS policy were included in Facility policy. Nevertheless, the Monitoring Team finds the Facility to have made progress and to be near to complying substantially with the requirements. For Provisions V2, V3, and V4, the Facility assessed that it was not yet in compliance. The Monitoring Team concurred. The Monitoring Team points out that the reasons for the findings, though, differ in some cases. For Provision V2, the Monitoring Team noted that the Facility self-assessment did not review implementation of policies to determine whether they were implemented consistently and accurately; this should be a part of the self-assessment, as the Provision requires not only development and revision of policies, but also implementation. For Provision V3, the Monitoring Team noted that some requirements of Appendix D of the Settlement Agreement were not being monitored, and some were consistently found to be not applicable (although the Monitoring Team found them often to be applicable, and even found them implemented accurately in most cases). For Provision V4, the Monitoring Team agreed with the measures being reviewed for the self-assessment (although it would be good to have data reported) but also adds the need to look more broadly at other measures of use of records. An Action Plan that accompanied the Self-Assessment listed action steps for each provision to guide the Facility through substantial compliance with each provision. Many actions were sequential and would build toward compliance. Some provisions required a broader view and a clearer statement of the status needed for compliance. For example, for Provision V2, all actions related to HIM/Recordkeeping policies, but the provision relates to all policies (Facility and Statewide) needed to implement Section II of the Settlement Agreement. For Provision V3, a sequence of actions was provided beginning with revising audit tools and leading to review of Corrective Action Plans for completion, but there were not actions to identify systemic issues and implement improvement initiatives to improve recordkeeping throughout the Facility. Nevertheless, the Monitoring Team would point out that the processes for Self-Assessment and Action Plans is a significant improvement compared to the process at prior compliance visits.

	Summary of Monitor's Assessment: RGSC has continued improvement in all areas of this Section. Although no provisions were yet found in compliance, continuing improvement and attention to a few issues should make compliance possible. For Provision V1, the Facility did have a Unified Record for each individual. Records were, for the most part, complete; however, a few items were consistently not found (and were noted both by the Monitoring Team and in the Facility's own audits as not present). Facility policies do not yet address all requirements of Appendix D of the Settlement Agreement. In some cases, current practice did address requirements that were not yet found in Facility policy. For Provision V2, the Facility continues to develop and revise policies, as does DADS. For both the Facility and DADS, many of the new and revised policies had only recently been implemented. Furthermore, there were instances identified throughout this report of lack of accurate implementation of policies, and the Facility does not have a process in place to track that. For Provision V3, the Facility has in place an audit process that has the potential for substantial compliance. As reported in the Self-Assessment, the interrater agreement process was recently established. One problem noted was that some items on the audit tool were uniformly marked Not Applicable, even though they were often applicable and usually in place (but not always); this was in spite of 100% interrater agreement that they were not applicable. Although the audit Corrective Action Plan had the potential to be an effective system that allows tracking of correction and of types of errors (and, in fact, the primary error was given in the Self-Assessment as a reason for noncompliance for Provision V4), corrective actions focused on errors in individual records and had not yet led to a focus on systemic improvements. For Provision V4, the Monitoring Team observed use of the records at meetings, staff reported that documents could be found, and staff could give examples of how they used records. The Facility had implemented the statewide interview process to ask IDT members about their use of records. The Facility needs to also look more broadly at other ways to identify whether records are being used. One means was actually reported in the self-assessment—tracking of whether assessments are completed timely (but tracking needs to involve timeliness so that records can be used in planning, rather than whether assessments are completed following planning sessions). In all, the Facility has made continuing progress but does not yet comply with any provision of this Section.

#	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	The Facility maintained a Unified Record for each individual. The unified record at RGSC consisted of an active record, individual notebook (the Me Book, separated by Residential and Vocational), Master Record, Overflow (which remains in the Master Record until the retention period is completed), and the Clinical Work Station (CWS).	Noncompliance

#	Provision	Assessment of Status	Compliance
	and maintain a unified record for each individual consistent with the guidelines in Appendix D.	The CWS, an electronic system, included progress notes, medical progress notes, nutritional reports (not including PNM), and psychiatric evaluations. In addition, assessments and some other information were copied to a share drive that was not considered part of the unified record but allowed information to be easily accessible to members of the IDT. HIM staff did filing and purging of documents in the active record. When monthly documentation was to be moved from the individual notebook to the active record, HIM staff were responsible for moving the documents. Because HIM staff did all purging, they could assure that all materials to be moved to overflow in the Master Record were filed there. <u>Recordkeeping Policy</u> Three policies governed recordkeeping. RGSC SOP HIM 400-07 ICF Documentation Guidelines guides documentation practices. Although worded somewhat differently from DADS Recordkeeping policy, it included (and for some requirements, provided additional guidance) all documentation requirements. Furthermore, the SOP included information needed regarding documentation in the CWS. RGSC SOP HIM 400-14 Filing and Purging of Information Policy/Procedure governed (as the title states) how filing and purging are to be done. RGSC SOP HIM 400-20 ICF-DD Monthly Record Review covered the requirement for monthly audit of the unified record (including CWS documentation) and individual notebooks; it provided a detailed process for this review. However, the Facility policy did not include a statement of the requirements in DADS policy for the components of the Unified Record ("Active Record, Master Record and/or Individual Notebook"). Nevertheless, the Facility did maintain these components. Facility policy also did not include the statements from DADS policy that "Medical Progress Notes must be integrated, including entries from at least Physicians, Physician Assistants, Psychiatrists, Dentist, Nurses, and Therapists." As noted below in discussion of the CWS, the current system makes integrating these progress notes cumbersome. <u>Accuracy and Completeness of Records</u> To determine whether Active Records were completed in compliance with Facility policy and Appendix D of the Settlement Agreement, the Monitoring Team reviewed the complete record for Individual #8 (selected through computerized randomization from among the five individuals whose records were due for audit) and the active record and individual notebook for Individual #46 (selected by coin toss from the two admissions since the last compliance visit), as well as audits conducted by the Facility in December 2011 and January 2012. In general, documents in the records were organized, and it was easy to locate relevant information.	

#	Provision	Assessment of Status	Compliance
		For Individual #46, all documents identified on the Table of Contents as required were present in the active record except the CLOIP Worksheet, pharmacy annual evaluation, and initial dental examination report. As this individual had been admitted to the Facility since the last compliance visit, it is possible these documents would not yet have been completed and would not have been expected to be in the record. Although the active record was generally in good condition, some documents were out of order, there were multiple copies of the same Structural and Functional Assessment, and there were numerous gaps at the bottoms of pages of physician orders. The individual notebooks for Vocational and Residential also contained all required documentation. The individual notebook for Vocational was in good order, but the individual notebook for Residential was in poor condition, with tabs out of order, pages facing different directions so it was difficult to tell which tabs documents followed (and some documents clearly in the wrong tab), blank data sheets for a program that was not found in the individual's ISP, and at least one undated document. The Facility might wish to consider auditing records of individuals newly admitted to the Facility prior to the usual due date (the Facility audits records in the month following the annual ISP planning meeting). Nearly all documents were also present in the active record and individual notebooks for Individual #8, with only the breast screening, menses record, and dental annual assessment not found in the active record, and the Critical Information/Special Considerations not found in the individual notebook for Residential (although present in Vocational). These missing documents were also noted by the Facility in its audit during the compliance visit. A few documents were not current (but were mostly only out of date by a short time), and documents were legible except for a diet record. The Master Record was in order and appeared to contain the required documents. Audit report tools for audits conducted in December 2001 and January 2012 reported similar findings. Documents were almost always present, some documents were not current, and CLOIP worksheets were uniformly missing (so the Facility should identify a means to ensure these are completed and entered into the active record). The audits uniformly checked N/A for gaps and for chronological order and legibility; these should be audited and documented whenever they are applicable (which, in the case of legibility, should be whenever there are documents in a specific tab). As the Monitoring Team reviewed a large number of records, additional errors were noted. For example: • Provision M1 noted that inappropriate and unapproved abbreviations were sometimes used. <u>Clinical Work Station</u>	

#	Provision	Assessment of Status	Compliance
		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 area. The Integrated Progress Notes, which were organized chronologically 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, as a single issue or concern could not be tracked chronologically without opening one discipline, then closing that and opening another to find relevant notes—a time-consuming process. This posed a barrier to integrating clinical data to provide useful information. Furthermore, as reported in Provision M1, late nursing entries occurred frequently because, according to reports from several nurses, the CWS system was down. <u>Accessibility and Security of Records</u> Active records were kept in a locked room in each of the two living units. Home staff were able to access the records as needed. A checkout list was in each room with the active records. Individual records were kept at the residential and vocational sites and were usually easily accessible. However, during one observation, members of the Monitoring Team found that individual records (which included the PNMP) were in a locked room and were not readily accessible for review of the PNMP during mealtime. The Monitoring Team also found one chart of the active record for Individual #46 not in the records storage room one evening, and the checkout record showed it had been returned from the last checkout; the next day, home staff reported the chart had been in the medication/nursing room across the hall at the time. It was not clear to the Monitoring Team whether this should have required checkout, but staff should be aware at all times of where the active record can be found. <u>Use of Share Drive</u> QDDPs demonstrated use of the Share Drive for posting and availability of assessments by PST members. The QDDP 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. Although the system of folders differed across QDDPs, they could easily navigate to the correct folder, identify which assessments were posted, and read them. The Monitoring Team asked three QDDPs to find assessments for the individual whose ISP annual planning meeting was to be held during the compliance visit. Not all required reports were present, and the QDDPs reported that the annual medical assessment is not posted for anyone. The QDDPs reported the Share Drive also contains an appointment schedule that they review to identify who will need special supports or pre-treatment sedation, and to see whether appointments planned at an ISP meeting was made. The Share Drive has great potential to be a valuable tool, if assessments are posted as required, and if a standardized system for folders is established so QDDPs and clinicians	

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		can easily access folders regardless of who is the QDDP serving the individual. <u>Conclusion</u> The Facility has come very close to substantial compliance. The Unified Record contained all required components. Active records were in good condition, with almost all required documents present and few errors when compared to Appendix D requirements; there was, however, no evidence that the Facility was addressing the consistent absence of the CLOIP document or identifying when there were gaps in documents. To achieve compliance, the Facility will need to ensure Facility policy matches and operationalizes all requirements of DADS policy, must ensure accessibility of records to staff who need them, must ensure all required documents are present and that the records do not contain gaps and are legible and in chronological order, and must find a way to integrate the progress notes of the various clinicians so they are easily usable for assessment and decision-making.	
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; the ICF-DD SOP manual was due for revision at the time of the compliance visit. A proposal for a new policy or a revision may come from a department, a committee, SA-PIC, or any staff member. 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. The Facility provided a flowchart that diagrams this process. Other than the flowchart, there was no written policy or procedure that described the process or any requirements of the process. When a policy is revised, notice is typically sent to department heads, who are to disseminate to their staff. However, the Facility did not have a process to determine whether the policy was actually disseminated, except that some policies have a test that would be returned with a training roster; completed tests would be placed in the individual employee's competency file. The Facility did not inform the Monitoring Team of any such policies implemented or retrained since the last compliance visit. The Facility provided the Monitoring Team with the following policies revised since the last compliance visit: • RGSC SOP HIM 400-07 ICF Documentation Guidelines revised 10/28/11 • RGSC SOP HIM 400 14 Filing and Purging of Information Policy/Procedure	Noncompliance

#	Provision	Assessment of Status	Compliance
		revised 1/30/12 • RGSC SOP HIM 400-20 ICF-MR Monthly Record Review Policy/Procedure revised 11/1/11 • RGSC SOP ICF 200 03 Incident Management revised January 2012 • RGSC SOP ICF 200 08 Protection From Harm—Abuse, Neglect, and Exploitation revised January 2012 • Improving Organization Performance Program revised 1/4/12 • RGSC SOP QA 100.014 DADS Quality Enhancement Expectations revised January 2012 • RG SOP ICF-DD 400 13 Psychiatry Services revised 11/18/11 In addition, the Facility provided information on a number of new procedures and forms. • A PNMT process was implemented 2/2/12. The Facility PNMT process, among other things, defined the roles and responsibilities of the PNMT and the collaboration that was intended to occur with the Interdisciplinary Team (IDT). Included in this process was a defined criterion that stated what incidents must be referred to the PNMT and what may be referred to the PNMT. As reported in Provision O1, the procedure needed to provide greater clarity about analysis of trends. However, although there was continued progress, some issues remained with the development, content, and implementation of policies. Following are some examples: • As reported in many sections of this report, there were examples of lack of implementation or inaccurate implementation of policies. • As noted above regarding the PNMT policy, there were examples in which policies needed greater clarity. • As reported in Provision I1, full implementation of at risk policy was not in place. • As reported in Provision L3, the Facility had not developed a process to conduct quality assurance review to assess the Facility's overall management of medical care. • As reported in Provision V4, assessments were not completed in compliance with Facility policy. DADS also continued to implement new policies or revisions of policies. Although not all necessary policies were yet developed, the following had been recently implemented: • Policy 3.1 Quality Assurance was revised 1/26/12 • Following the conclusion of the compliance visit, DADS implemented Policy 019 Guardianship on March 7, 2012. To show implementation and training of relevant staff on both the state policies and the	

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		facility-specific policies, the facility should develop a policy and system with the following components: • It should incorporate mechanisms already in place, such as an email/correspondence being sent to the departments impacted by the policy, including the list of job categories to whom training should be provided. • For each policy, consideration should be given to defining who will be responsible for certifying that staff who need to be trained have successfully completed the training, what level of training is needed (e.g., classroom training, review of materials, competency demonstration), and what documentation will be necessary to confirm that such training has occurred. It would seem that sometimes this responsibility would be with the Competency Training Department, but often others would have responsibility. • Timeframes also would need to be determined for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or refresher training (e.g., ISP annual refresher training). • A system to track which staff had completed which training. The Facility should also maintain a list of SSLC statewide policies and the corresponding Facility policies. Conclusion: Both the Facility and DADS continued to make progress toward implementing policies needed to implement Part II of this Agreement. The Facility needs to expand processes to ensure staff are aware of, understand, and implement policies accurately. •	
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	SOP HIM 400-20 governed the process for monthly record review. This policy requires audit of at least five individuals every month selected from the annual staffing list for the month reviewed. Although the policy does not call for random selection, in practice, the Facility reviewed records for all individuals following annual ISP planning meetings. Documentation of audits conducted in December 2011 and January 2012, along with the schedule of audits for March 2012, verified that the Facility audits records of at least five individuals every month. These audits were done (and are scheduled) for each individual who had an annual ISP planning meeting the prior month; per report of HIM staff, if there are not five individuals with an annual ISP planning meeting in a month, an individual is selected from the next month's ISP meetings. <u>Audit Process</u> Since the last compliance visit, the audit process had been revised to include audits of	Noncompliance

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	review to ensure that adequate corrective action is taken to limit possible reoccurrence.	individual notebooks and of progress note entries in the CWS. HIM staff did audits in a consistent manner, using the Active Record Audit Tool, which had separate sections for each chart and for the Residential and Vocational individual notebooks. The audit tool included most requirements of Appendix D. This tool was a single form that had places to document for each section of the record (tab) 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 (which was included as a single item with the unrelated item of chronological order) or of the process to correct errors. These should be added to the form. The staff auditing the record marked Yes, No, or NA for each item. Uniformly, they marked NA for "No gaps between entries" and "Entries in reverse chronological order/legible." These should be checked also. Facility policy required audits to be done in the first week of the month following the ISP planning meeting for selected individuals (as noted above, practice was to do this for every individual in the month following the ISP planning meeting). Following the audit, HIM staff selected one record for completion of the State Office interview tool for Section V4 to assess whether staff routinely use individuals' records in making care, medical treatment, and training decisions. <u>Interobserver Agreement</u> Since the last compliance visit, the Facility had initiated interobserver agreement checks of audit findings. SOP 400-20 required secondary audits to be conducted on one chart monthly. The Facility reported it had established a process for interrater audits that began in October 2011. A second auditor picks one record for an independent review done the same day as the primary review. Raters do not look at each other's ratings in doing their audits. Following completion of both audits, the raters check for agreements and disagreements (note that they count agreement on NA ratings as agreement, which is acceptable except for their uniform rating of NA for two Appendix D requirements). They discuss the reasons for disagreements but do not track those; this could lead to improved agreement but drift away from accurate findings. The Monitoring Team recommended they track all reasons for disagreements and periodically revise the definitions and instructions to auditors.	

#	Provision	Assessment of Status	Compliance
		The Facility provided the Active Record and Individual Notebook Audit Tools for the interrater agreement audit in January 2012 for Individual #84. One HIM staff did the primary review for the active record and secondary review for the individual notebook; another HIM staff did the reverse. The two raters found 100% agreement. Given that every tab showed NA for gaps and chronological order/legible, this would indicate that there is an expectation these will note be rated, yet they remained in the tools and were presumably counted in any calculation of percent of compliance. The Monitoring Team will be interested in reviewing more of these checks at the next compliance visit. The Monitoring Team selected one record that would be due for audit in March 2012 and requested that the Facility audit the record and then provide it immediately to the Monitoring Team for an independent audit. The Active Record and Individual Notebook (both Residential and Vocational) were audited, with the following findings: • For presence of documents, agreement between the Monitoring Team and the Facility audits was 97%. This is evidence that the Facility provided clear definitions of presence and audited accurately. • For the criteria used for tracking whether records were current, signed and dated, had no gaps, were in reverse chronological order/legible, and were addressographed/labeled, agreement between the Monitoring Team and Facility was 79%. Although at the border of acceptable agreement, the vast majority of disagreements were ones in which the Facility documented "N/A" for the criteria of "No gaps between entries" and "Entries in reverse chronological order/legible." For most of those, the Monitoring Team documented "Yes"'; therefore, the Facility did not give itself credit for meeting requirements of Appendix D. The Facility should ensure all criteria that are actually applicable are audited and reported. Based on the above information, the audit process appeared to result in accurate findings, with the exception that it did not routinely report on gaps between entries and on chronological order or legibility. Because some tabs included only one document, the issues of chronological order and gaps is not applicable in those tabs. Because many documents are printed rather than handwritten, those would almost always be legible. Nevertheless, the Facility should document whenever applicable. The Facility should also check Appendix D to ensure all requirements are audited. <u>Audit Findings</u> Overall, the audits found the records to be mostly complete and accurate. As noted in Provision V1, the audits found nearly all documents to be present, although there were some documents not found (including, for nine of the 10 records audited in December 2011 and January 2012, the CLOIP Worksheet, as well as numerous assessments that	

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		were missing or outdated and Integrated Risk Rating documents for five of the 10 records). Audits found a few examples in which documents were not current but almost no other issues with Appendix D requirements (but note that gaps, chronological order, and legibility were all found N/A); one item for one individual was marked No for lack of date. <u>Corrective Action Planning and Monitoring of Trends</u> SOP HIM 400 20 laid out the process for reporting findings and for corrective action planning. It listed the facility staff who are to receive the results of the audits. It stated that data will be trended by discipline and where these results will be provided. It required Corrective Action Plans (CAPs) to be submitted one week following the audit, and that CAPs will "include assessments not cleared or still pending from prior audits." Items needing correction were listed on the Action/Corrective Action Reporting Document. A separate document was completed for all the items for which a specific staff was responsible for corrective action; this could include items from more than one individual's record. For example, one document for December 2011 included a number of assessments not current along with the Integrated Risk Rating and CLOIP forms for two individuals for whose records one QDDP was responsible; each of four QDDPs received this document for two individuals (for a total of eight, although only five audits were provided to the Monitoring Team—the other three individuals were the first three to have an ISP planning meeting in November and presumably might have been audited in November to fill the number required for that month). These documents included a listing of the issues needing correction, the corrective action needed, who they are assigned to for correction, date initiated, date of expected completion, dates of follow-up requests if needed, type of evidence completed (all forms either left this blank or stated "Findings should be completed and sent to HIM for clearance and filing."), and a place for comments. When a correction was cleared, a note was put next to it on the document so it was easy to track what remained. The note stated the item was "cleared" and gave the date. Because almost all corrections involved missing documents (mostly assessments), the Monitoring Team assumed "cleared" meant the documents had been provided and filed. For one item—lack of a signature and date—it was not obvious what was meant by "cleared"; it would be better to state specifically how the item was corrected. There were no items that could not be corrected (such as inaccurate or missing progress notes, that should not be entered unless done as a late entry), so there was no way to assess how that would be documented. Nevertheless, this process seemed to provide a way to track and document completion of corrective actions.	

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		It should be noted that the HIM staff do the filing in records, so they noted that items were corrected after they did the filing. HIM staff reported they immediately correct issues like gaps at the bottoms of pages. Therefore, they did not have a process to do an independent review to confirm that filing of documents had been done. HIM reported they do check when other corrections, such as missed signatures, are reported to be completed. In response to a document request for the most recent report of data showing trends in audit findings, the Facility provided the ICF Monthly Delinquent Assessment Report but did not provide any reports showing other findings relative to requirements in Appendix D. The monthly assessment report began in September 2011, so it had four months of data. These data, per Facility report to the Monitoring Team, reported whether assessments were completed within 30 days following the ISP annual meeting. This monitoring does not provide adequate information to identify actions that need to be taken (for example, it did not identify that CLOIP Worksheets were almost uniformly not found in the active record) nor to identify the status of Appendix D requirements. Even in relation to the one issue tracked, it did not identify whether assessments were available for use at in ISP planning; as noted in Provision V4, a report of assessments completed within 10 days of the ISP annual planning meeting showed 30% completion. The Facility should identify and implement a process to track and trend essential issues in ensuring a usable and accurate record that meets requirements of Appendix D. HIM staff reported in interview that they provide data from the primary auditor for trending, but no information other than delinquent assessments was provided to the Monitoring Team. <u>Additional Audits</u> The Facility also reported auditing all physician orders for each individual to make sure all telephone and verbal orders are signed, dated, and timed within 48 hours. The Facility provided a form called Authentication of Verbal Orders that tallied all verbal and telephone orders by individual and clinician; only a few listed date/time of order and when signed, so it was not clear how this audit was carried out. A graph was provided of the numbers of such orders from September 2011 through January 2012. The Facility also reported auditing a sample of contracted and consultant services. Conclusion: RGSC continued to make progress toward compliance with this provision. To comply with this provision, the Facility will need to ensure all requirements of Appendix D are audited. Although the audits have resulted in CAPs for individual records and a process to track completion of required actions, there has been little done to identify systemic improvement actions needed. Tracking of delinquent assessments was done, and the	

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		Monitoring Team will look forward to seeing whether improvement actions to reduce these are effective so that assessments are available in time to be useful in ISP planning.	
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.	Continued progress was being made in use of records for decision-making. However, issues with accessibility of records, completion of assessments, and decisions that seem not to be based on available data make clear that there is still room for improvement. <u>Records are accessible to staff, clinicians, and others</u> RGSC was not yet assessing this. The Monitoring Team noted that active records were kept in a locked room in the living unit, and that staff had access to the room and could easily access the active records. A book was available for identifying when records were checked out and returned, and one book checked by the Monitoring Team showed current use. Individual notebooks were set up for Residential and Vocational so they did not have to travel between living and day program sites. However, some problems with accessibility were found: • The Monitoring Team found one chart of the active record for Individual #46 not in the records storage room one evening, and the checkout record showed it had been returned from the last checkout; the next day, home staff reported the chart had been in the medication/nursing room across the hall at the time. • As noted in Provision O4, the Monitoring Team noted during observations in houses that the individual notebooks were locked in the computer room lined up above the computers with the door closed and locked; therefore, they were not readily available to staff if needed. • At one observation at a living unit, the Monitoring Team found some individual notebooks at the front desk rather than near the individuals. <u>Observation of use of records</u> The Facility was not doing observation to assess use of records. Based on Monitoring Team observation of meetings and review of records, such use was mixed. Records were routinely referred to at meetings but not always at other times to make decisions. Examples include: • At the ISP annual planning meeting for Individual #97, the active medical record was referred to during the meeting to clarify clinical issues. • As noted in Provision O4, at no time during any of the observations was staff observed referring to the PNMPs. • As reported in Provision K4, for Individual #134, following the implementation of a PBSP in August 2011, verbal threats increased and remained above pretreatment levels through January 2012. During that same period, measures of mental illness remained at zero. Despite these circumstances, no revision to the PBSP was attempted, but psychotropic medications were increased twice.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• As reported in Provision S1, for Individual #55, the ISP narrative reflected that the individual used money for purchases. The ISP also included statements that indicated the individual possessed no concept of the purpose of money. Although it was possible that different assessments produced conflicting findings, one purpose of the ISP meeting is to resolve such conflicts and identify the most relevant training objectives. There was no indication that such a process was utilized in the development of the ISP. • Because the progress notes in the IPN could not be opened in a chronological manner across disciplines, gathering information about specific ongoing conditions and services is cumbersome, which inhibits interdisciplinary planning. <u>Availability of assessments</u> As reported in Provision F1c, reports on completion of assessments provided varying data. Because the important issue is the availability of assessments for annual planning, the most important information is the availability prior to ISP annual planning meetings. The Facility provided an ISP tracking log, titled "Annual Assessments Filed Within 10 Days," which reported the timeliness of assessments, by discipline, for ISPs conducted between 8/1/11 and 1/31/12. This reported an overall compliance rate of 30%, meaning only 30% of assessments needed for an ISP meeting were completed within 10 days of the meeting (presumably, that meant at least 10 days prior to the meeting), and filed in the shared drive, for other members of the IDT to review prior to the ISP meeting. Some examples of compliance rates by discipline are: • Health risk assessment 0% • Functional skills assessment 25% • OT/PT assessment 61% • Comprehensive functional assessment 9% • Adaptive living skills assessment 43% • Speech assessment 20% • Nursing summary 17% • PNMP 25% During interview with QDDPs, as reported in Provision V1, assessments were checked for Individual #97, whose ISP annual planning meeting was being held during the compliance visit and whose assessments were therefore due. Not all assessments were yet posted, so IDT members could not review them in preparation for the meeting. The QDDPs reported they had been told completion of assessments had improved, and that it was now occurring at a completion rate of 66%, but no similar documentation was provided to the Monitoring Team. The QDDPs reported they print the assessments to	

#	Provision	Assessment of Status	Compliance
		take to the ISP planning meeting. <u>Staff surveyed/asked indicate how the unified record is used as per this provision item</u> Each month, following audits, HIM staff selected one record for completion of the State Office interview tool for Section V4 to assess whether staff routinely use individuals' records in making care, medical treatment, and training decisions. The interview tool was sent out to all IDT professionals involved in documentation of care, and these professionals were asked to return the completed interview tool within 15 days. Responses to the tool were pasted on one complete interview tool, and HIM staff identify and share issues that may have been noted. The Facility did not have a process to track or trend responses to this survey. The Monitoring Team did not review completed tools as part of this compliance visit. However, an interview was conducted with two habilitation staff using the same tool but asking the questions generally rather than about a specific individual. These staff were able to provide examples of using information from the record for making decisions, and they stated they are able to find the documents they need in the record. Conclusion: The Facility has improved in using information from the record to make decisions. However, there were still examples in which information from the record was not used, and the lack of timely availability of assessments makes it difficult for IDT members to review the information from other disciplines so they can be prepared to hold integrated and informed discussions at planning meetings. 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. To demonstrate compliance, the Facility will need to demonstrate information from the record is used throughout the process of assessing status of individuals and the need for revision in treatment and supports, as well as 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. There will need to be evidence that staff actually use the information in the record as they provide services and implement planned supports daily.	

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

1. The monthly record audits should check for chronological order and for gaps, should separate legibility from chronological order, and should check for whether error correction is done per policy. (Provisions V1 and V3)
2. 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 V1 and V4)

3. Identify and implement a process to track and trend essential issues in ensuring a usable and accurate record that meets requirements of Appendix D. (Provision V3)
4. Expand processes to ensure staff are aware of, understand, and implement policies accurately. (Provision V2)

List of Acronyms

Rio Grande State Center
February 7-March 2, 2012 Compliance Visit

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
APL	Active Problem List
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	Electroencephalogram
EKG	Electrocardiogram
ER	Emergency Room
FA	Functional Analysis or Functional Assessment
FBA	Functional Behavior Analysis or Functional Behavior Assessment
FFAD	Face-to-Face Assessment/Debriefing
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
PMR	Psychiatric Medication Review
PMT	Psychotropic Medication
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
QDDP	Qualified Developmental Disabilities Professional
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietician
RN	Registered Nurse
r/o	Rule out
ROM	Range of Motion
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAM	Self-Administration of Medication
SFA/SFBA	Structural and Functional Assessment/Structural and Functional Behavior Assessment
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SO	State Office
SOAP	Subjective, Objective, Assessment/Analysis, and Plan charting method
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