# United States v. State of Texas

## Monitoring Team Report

**Rio Grande State Center**
**August 27-31, 2012**

**Date of Report: November 19, 2012**
**Submitted By: Michael J. Davis, Ph.D.**
**Monitoring Team: Michael J. Davis, Ph.D., BCBA-D**
**Monitoring Team:**
**Dwan Allen, RNC, BSN, NP**
**James Bailey, MCD-CCC-SLP**
**Rod Curtis, M.D.**
**Douglas McDonald, Ph.D.**
**Scott Umbreit, M.S.**

## Table of Contents

# 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 Director, Sonia Hernandez-Keeble, was extremely supportive of the Monitoring Team's activities throughout the week of the compliance visit. 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 Alondra Machado, Rosie Sanchez, and Angie Alejo. 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. The Facility provided a self-assessment and action plans for each section of the Settlement Agreement. For the self-assessment, the Facility reported for each provision the activities engaged in to conduct the self-assessment, results of the self-assessment, and a self-rating with rationale for the rating. The self-assessment process has become more thorough and objective. In general, improvement was noted in the organization and presentation of the Self-Assessment. A notable attempt had been made to mirror the tools and processes used by the Monitoring Team. However, as indicated in each of the sections of the report below, self-assessments varied greatly across sections of the Settlement Agreement. For some sections, the Facility used data gathered as part of routine quality assurance and quality improvement activities, which is commendable. In other cases, data were gathered specifically for the self-assessment. In many cases, data were not gathered at all. In some cases, data that represented positive findings was, and in other cases was not, verified by the observations done by the Monitoring Team. For many provisions, the self-assessment did not cover all essential requirements of the provision. 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 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. For many of the sections, most action plans were described as "In Process". Many of these were actually descriptions of ongoing processes rather than identification of particular outcomes needed for compliance and a sequential plan of action to reach each outcome. The Facility should determine and describe organized, sequential plans for specific actions to progress toward compliance overall as well as for specific sections.

## 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. Overall, documentation on Restraint Checklists and Face to Face Assessment/Debriefing documents was much improved. While the number of crisis intervention restraints increased from that reported in the last review, restraint use is limited to a small number of Individuals.

- Positive Practices and Improvements Made

- The rate of restraint use at RGSC, which was noted to have decreased significantly in the last review, continues to remain low even though the number of restraints has increased. This is the case with both crisis intervention and medical restraints. During this review period the use of crisis intervention restraint increased but was used with only four Individuals.
- The Facility reported no use of medical restraint for dental procedures and limited use for medical procedures. The administrative initiatives noted in previous 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. However, none of the Individuals for which medical restraint was used had supports in place to minimize or eliminate the need for restraint.

- Improvements Needed
  - As noted above, none of the Individuals for which medical restraint was used had supports in place to minimize or eliminate the need for restraint.
  - Examples were identified in which restraints occurred that were not in accordance with applicable written policies, procedures, and plans governing restraint use.

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

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

- Positive Practices and Improvements Made
  - The Facility's policies and procedures include a commitment that abuse and neglect of individuals will not be tolerated, and require that staff report abuse and/or neglect of individuals.
  - 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.
  - The video surveillance cameras had been helpful in ascertaining the facts associated with many allegations.
  - Staff training requirements are current. The Facility had an ongoing system for on-the-spot competency testing to ensure staff retains the key requirements of abuse/neglect training.
  - All allegations of physical abuse were appropriately referred to law enforcement.
  - The Supervisor of DFPS Investigators, his supervisor, and an OIG Investigator all expressed a high level of cooperation between Facility administrative staff and themselves.
  - The Facility has made office space available to DFPS, and DFPS now has an investigator working out of this office on a regular basis. It was reported that this has facilitated better, and timelier, communication between the Facility and DFPS.

- All investigations reviewed by the Monitoring Team began within 24 hours of being reported and were completed within 10 calendar days of the incident.
- Tracking and trending data was complete and regularly analyzed.
- Employee background checks occurred as required by State policy.

- Improvements Needed
  - The frequency of late reporting of allegations of abuse and neglect remains a concern.
  - The content of some investigations, particularly those conducted by the Facility, need improvement. They do not always address obvious considerations in the conduct of a good and thorough investigation.
  - 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.
  - Presentation of information in UIRs was not always organized in manner that ensures all the requirements of the SA can be readily identified to determine compliance.

Quality Assurance

Although no provisions were found in substantial compliance, the Facility had laid a foundation for an effective quality assurance program.

- Positive Practices and Improvements Made
  - The Facility had updated its Quality Assurance policy and its Improving Organizational Performance Program document.
  - The Facility had implemented tracking and trending in subject areas it determined were important after review of other trend data. For example, in reviewing injury data the Facility determined it was important to separately track falls and injuries that resulted from peer-to-peer aggression, and frequently injured individuals. The Facility is to be commended for using basic trend data to identify the need for more finite data collection and tracking.
  - Since the last review several improvements had been made to CAP reporting. One particularly significant improvement was, at the time of CAP initiation, each CAP was designated as "high urgency" or "low urgency."
  - As noted in the last report, 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 to encourage those reviewing data reports to engage in critical thinking. The Monitoring Team observed continued implementation of this process.
- Improvements Needed.
  - The Facility collects data which is tracked and trended for most provisions of the Settlement Agreement; however, data collection, reporting, and trending were not consistent in all areas of the ICF-ID program.
  - Since the last review the Facility had developed some Corrective Action Plans (CAPs) to address systemic issues. This was a new process and still being refined.

- 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.
- The vast majority of CAPs (including those designated as high urgency) are not completed timely.
- The Monitoring Team did not identify substantive activity occurring that would measure whether any set of activities implemented in multiple CAPs directed at similar subject matter (i.e. Incident Management or infection control) were effective in preventing the recurrence of problems.

Integrated Protections, Services, Treatments and Supports

The new ISP process developed by DADS was implemented during the compliance visit. The Monitoring Team review was based on ISP planning meetings held during the compliance visit and on ISPs developed through this process. With an understanding that this process was newly implemented, the Monitoring Team found the Facility's progress had not been substantial in developing and implementing 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, although some improvements were identified.

- Positive Practices and Improvements Made
  - DADS had provided training to QDDPs and clinical staff on the new ISP process and on development of skill acquisition plans. The Facility had plans for additional training from DADS.
- Improvements Needed
  - Assessments were not consistently completed timely or updated as the need arose. Assessments by some disciplines had improved and were comprehensive, but this was not the case for all clinical disciplines.
  - Although IDT member attendance at the two observed annual ISP planning meetings was appropriate, documentation provided by the Facility indicated that attendance did not meet the requirements of this Section.
  - Although it was clear that teams were trying to identify and incorporate individuals' preferences, the new ISPs did not provide evidence that IDTs were skilled at identifying preferences or at identifying supports and services that addressed preferences in a meaningful way.

Integrated Clinical Services

The Facility had continued to progress toward providing clinical services in an integrated manner. Policies and processes to improve integrated planning both for individuals and for systemic improvements continued to evolve. Nevertheless, integrating planning and services across disciplines remained a challenge.

- Positive Practices and Improvements Made

    - There were examples of improved integrated clinical services. The Infection Control Preventionist maintained Antibiotic Susceptibility of Common Organisms Reports, attended the Pharmacy and Therapeutic Committee Meetings and shared the information with the Pharmacist and physicians. The Medication Administration Workgroup meetings were integrated and involved participation by several disciplines, as were the Pharmacy and Therapeutics Committee meetings.
    - One positive finding was the continued evolution of the Morning Medical meeting, which was now called the Team Integration Meeting; as this meeting continues to evolve, it should provide a good opportunity to expand further integrated planning on both individual and systemic issues.
- Improvements Needed
    - Attendance by various clinical disciplines at the annual ISP planning meetings needed to improve.
    - Assessments for the ISP were still not consistently completed on a timely basis.
    - Medical issues are not well integrated into the IDT process.
    - The Facility used a consultation form to document review by Facility physicians of non-Facility consultant reports. For each, an Integrated Progress Note was to be written. There was no similar process for other (that is, nonmedical) clinical consultations. Consultation forms generally provided documentation of agreement or non-agreement with recommendations. IPNs were not consistently found, and there was no evidence on these forms or in IPNs of referral to the IDT, although a process reportedly existed that included IDT review of consultations.

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

There had been modest progress in most areas of this Section. Comprehensiveness of assessments had improved for some disciplines but not others, timeliness of assessments and implementation of treatments remained problematic, and there had been limited development and use of systemic clinical indicators of health status.

- Positive Practices and Improvements Made
    - Comprehensiveness of assessments had improved.
    - Diagnoses were consistent with the current versions of the DSM and ICD classification systems, and were generally consistent with the supporting assessments.
    - Assessing acute medical conditions was occurring more proactively and promptly, and consultations were being provided more assertively.
- Improvements Needed
    - 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 the Facility had continued to develop systemic clinical indicators of efficacy of treatments and interventions in health care and other clinical areas, and some of these indicators had become integrated into the key indicators used by the Facility for quality review, this remained in early stages.

- Improvement is needed in using clinical indicators to determine the need for revision in treatments, particularly in clinical areas other than medical care.
- Policy to identify common elements of clinical care and to provide guidance continues to need development and implementation.

At-Risk Individuals

Although at the prior compliance visit, the Monitoring Team expressed optimism that recent administrative process that were reported as just having been put in place would lead to improved compliance, that did not prove to be the case. The Facility reported staff recently received training on risk assessment and that the At-Risk policy had been updated, both of which should lead to improvement.

- Positive Practices and Improvements Made
  - The Facility reported it had trained staff in late July on the IDT process for risk assessment that State Office had promulgated some months earlier.
  - The Facility had also updated its At-Risk policy (ICF-IID 400 02) in August, 2012 to include revisions associated with the revised State policy.
- Improvements Needed
  - Observation of ISP planning meetings indicated need for improvement in risk review, discussion, and decision-making.
  - The Facility did not always adequately respond to individuals who had a change in health status that should have resulted in risk screening, and/or change in risk ratings, and/or the initiation of, or change in, risk action plans.

Psychiatric Care and Services

The Monitoring Team noted continued and significant progress towards substantial compliance with Provision J of the Settlement Agreement.

- Positive Practices and Improvements Made
  - The Facility maintained adequate staffing for psychiatric services, through a full time equivalent contract psychiatrist that was fully supported by the clinical director, who provided backup and ten hours of direct psychiatric services per week.
  - Psychiatric assessments included robust use of behavioral data to support both diagnosis, and treatment strategies.
  - Each individual's prescribed psychotropic medications are carefully evaluated by a psychiatrist, who assigned a clinically justifiable diagnosis.

- Improvements Needed
    - The Facility had yet to develop strategies to address the review of pre-treatment sedation, and to develop meaningful strategies to help mitigate the use of pre-treatment sedations.
    - Although the Facility developed and implemented a robust process that helps to ensure collaboration among psychologist, and psychiatrist to include behavioral data in the psychiatric assessments, and to consider and review non-pharmacological treatments, the Monitoring Team could not confirm that this had resulted in integrated planning.
    - The Facility did not discuss alternate treatment options during quarterly psychotropic medications. There is a need to document that all risks and benefits, and alternate treatment, including no treatment. There should be review by the IDT prior to initiating any non-emergency use of psychotropic medications.
    - The Facility needs to develop and implement a system to monitor, at least monthly, the prescriptions of polypharmacy.
    - A formal policy and procedure must be developed that outlines the process for psychotropic medication treatment plans, ensures that the expected timeline for the therapeutic effects of the medication to occur is stated, and delineates by whom, how, and when monitoring for efficacy should occur.
    - The Facility must implement a more meaningful consent process.
    - The Facility must develop and implement a process that ensures that neurologist and psychiatrists collaborate when prescribing antiepileptic drugs for combined psychiatric and neurologic conditions. Such collaboration must be reflected on relevant psychiatric assessments and psychotropic medication reviews.

<u>Psychological services</u>

RGSC had achieved meaningful progress in several areas of this Section, but many new procedures had only recently been implemented, and only a small sample was available for review. There were other areas in which either minimal progress had been achieved or evidence supporting improvements was not provided.

- Positive Practices and Improvements Made
    - Both internal and external peer review had been enhanced.
    - There was an increase in the number of psychological evaluations and intellectual and adaptive assessments provided.
    - Data graphs for PBSPs had been substantially enhanced.
- Improvements Needed
    - Although staff had reported significantly enhanced integration between psychology and psychiatry, a review of psychological evaluations, PBSPs, and SFAs did not reflect this integration.
    - There were substantial delays in the implementation of PBSPs.

Medical Care

The Monitoring Team noted significant and continued improvement with the provision of medical services at the Facility.

- Positive Practices and Improvements Made
  - Physical examinations conducted for annual medical assessments and acute care conditions were more comprehensive.
  - Assessing acute medical conditions was occurring more proactively and promptly, and consultations were being provided more assertively.

- Improvements Needed
  - Not all identified clinical conditions are listed as an actual diagnosis, and action plans are not always delineated for each diagnosis.
  - Chronic care issues should be addressed and reviewed either at a quarterly medical assessment, or as recommended by relevant professional organizations.
  - The Facility had yet to develop a meaningful process to manage clinical database elements.
  - There remained deficiencies with regards to monitoring and following up on individuals who were at risk for bowel impaction and obstruction, and it is essential that policies, and practices are developed that will ensure appropriate monitoring and follow-up occurs.
  - The Facility had yet to fully implement a process that enabled an assessment of the primary care physician clinical performance.
  - The mortality review process needs to identify system issues to be addressed.
  - The Facility did not have a process in place that would enable s systems review of clinical outcomes.
  - The Facility must implement meaningful medical policies.

Nursing Care

Overall, RGSC did not appear to be moving forward in a positive direction with regard to providing nursing services. This most likely was attributable to the 45% turnover rate of the nursing staff, particularly the nursing administrative and management staff, coupled with the necessity to rely on approximately 50% contract nurses to provide direct nursing services.

- Positive Practices and Improvements Made
  - The Nurse Educator continued to maintain a Nursing Training Tracking Database to verify the required nurses' training.
- Improvements Needed
  - The Facility must address the high turnover rate in nursing staff, including nursing administration.

- The nursing assessment failed to summarize concisely and succinctly individuals' health status progress in relation to their identified risk ratings and/or active medical problems that required nursing interventions.
- The care plans developed and implemented in relation to individuals' identified risk ratings and/or active medical problems were not individualized sufficiently to meeting individuals' specific needs.
- The Facility had not adopted and implemented the final Medication Variance Policy, 053. The Facility needed to further analyze medication variance data to ensure that all medication variances, committed by all disciplines, are identified and appropriate corrective action taken to prevent and/or minimize their reoccurrence. While the nursing staff had a general knowledge of dysphagia, they lacked the knowledge to fully understand and implement strategies related to PNM to ensure safe medication administration practices.

Pharmacy Services and Safe Medication Practices

The Monitoring Team noted significant improvement with organizational efforts within the pharmacy department. For example, documentation of QDRRs was concise, several new policies were developed for pharmacy operations, and steps taken to work towards compliance were effectively conveyed to the Monitoring Team. The Monitoring Team noted marked improvement with follow-up efforts on review of new medication orders, and rated substantial compliance for Provision N1. Also, much improvement was noted with Provision N2, by enhancing its review process for QDRRs. The pharmacy, however, has many noted deficiencies that must be addressed before substantial compliance can be achieved.

- Positive Practices and Improvements Made
  - The Monitoring Team would like to acknowledge the high quality of medication regimen reviews conducted by the dispensing pharmacist, when completing new medication orders.
  - The Monitoring Team was exceptionally pleased with improvements made by the Facility with regards to medication variance, including the development and implementation of a medication workgroup, and its enhancement of the reporting and review process for medication variances, by developing a very useful graphing tool to capture medication variance data elements.
- Improvements Needed
  - The Monitoring Team noted significant improvement with the QDRR process. Compliance will requires that the use of benzodiazepines, anticholinergics, polypharmacy, and STAT medications are included in the review clearly and clinical appropriateness clearly delineated.
  - There must be enhancement of its metabolic syndrome reviews, which must include abdominal circumference, documentation of a comprehensive review of metabolic syndrome on the QDRR report, and ensure that there are robust clinical recommendations on how to address metabolic syndrome, and/or risk factors for metabolic syndrome.
  - It is essential that all instances when the physician does not follow the recommendations by the pharmacist a clinical rationale for not following the recommendations is well documented, along with an alternate action plan.

- The Facility must develop and implement a process that ensures robust monitoring, clinical assessment, reporting, and follow-up on all Adverse Drug Reactions (ADRs). All relevant staff including nurses, physicians, direct care staff, and pharmacists must be well trained on the Facility's ADR process.
- Although the Facility updated its policy for DUE, there was no evidence to support implementation of the policy.

Physical and Nutritional Management

Overall, RGSC appeared to moving in a positive direction with regards to providing physical and nutritional services. Improvement was evident with the PNMPs as they were noted be more comprehensive.

The PNMT met regularly, which was positive, but lacked evidence of clear analysis of the reason for referral as well as providing a clear framework for identifying the assessments needed to revise current plans of care and thus mitigating the risk associated with the referral.

The monitoring system remained informal and continued to focus heavily on mealtime with very little focus on areas outside of oral intake.

- Positive Practices and Improvements Made
  - The PNMT met regularly.
  - PNMPs were more comprehensive in addressing all areas in which physical and nutritional risk may be increased.
- Improvements Needed
  - Timeliness in which the team responds to changes in status and the reassessment of individuals who have experienced a change in status must be improved.
  - 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.
  - Staff was observed not implementing PNMPs or displaying safe practices that minimize the risk of PNM decline. Per interview, staff was not knowledgeable of the plans and why the proposed strategies were relevant to the individuals' well being.
  - There was no 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.
  - 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.
  - 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. There was not a formal process in place that ensures individuals with increased PNM issues are provided with increased monitoring.

- All Individuals did not receive an annual assessment that addressed potential pathways to improved oral (PO) status. An assessment (MBSS) was conducted but potential pathways to increased intake were still not comprehensively addressed.

Physical and Occupational Therapy

Overall, improvement was noted with the comprehensiveness of the OT/PT assessments as well as with staff implementation of the PNMPs. Assessments still require additional work to be considered comprehensive as information regarding community placement, schedule for monitoring as well as comparative analysis remained lacking. Additionally, a system must also be developed that will ensure all individuals are provided with a level of monitoring that covers all areas in which their risk may be increased and one that provides increased monitoring for those who require the greatest assistance.

- Positive Practices and Improvements Made
  - Assessments were completed in accordance to the schedule set forth by RGSC.
- Improvements Needed
  - Assessments were not being consistently completed in response to a change in status.
  - Assessments were not comprehensive.
  - Assessments were not consistently provided in time for them to be utilized in the planning of the ISP.
  - 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.
  - Therapy services were not consistently integrated into the ISP.
  - A system must be developed to assure that individuals are monitored in all areas of increased risk.

Dental Services

The Monitoring Team noted that the Facility had made some progress with regards to dental services, primarily in the area of oral hygiene, and by enhancing resources to support administrative functions for dental services. Because of fragmented oversight, the Facility made little other progress towards compliance.

- Positive Practices and Improvements Made
  - The Facility had increased the contract hours of the Facility's contract hygienist from ten to 20 hours per week, and the Monitoring Team was informed that the hygienist will assume responsibility of leading dental activities for the Facility in the near future.
- Improvements Needed
  - Dental services at the Facility remain fragmented, and without formal operational procedures, and practices.

- The Facility did not have a mechanism to efficaciously and efficiently track dental services, and was unable to provide meaningful clinical information and data related to oral health care at the Facility.
- At the time of this review, the Facility did not have a formal dental office, or appropriate staff assigned to oversee the delivery and outcomes of dental services.
- The Facility did not have a process to provide Quality Assurance for dental services.
- The Facility provided only minimal attempts at programs to minimize use of dental sedation, such as dental desensitization, and did not closely monitor the use of pre-treatment sedation and anesthesia.

Communication

There were many positives noted within this section. The number of shared devices continued to increase 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.

Communication assessments have become more comprehensive and were noted to do a better job at clearly identifying the individual's communicative strengths and weakness. More collaboration remained needed with behavior supports so that there was a cohesive approach to addressing problematic behaviors that had communication as a primary component.

- Positive Practices and Improvements Made
  - Communication assessments have become more comprehensive and were noted to do a better job at clearly identifying the individual's communicative strengths and weakness.
  - The number of shared Augmentative and Assistive Communication (AAC) devices continued to increase across campus thus allowing greater access to said devices.
- Improvements Needed
  - RGSC did not have a comprehensive communication procedure/policy that addressed all components of a functioning system.
  - The communication assessments did not consistently include the following elements:
    - Recommendations for direct interventions and/or skill acquisition programs including the use of AAC as indicated for individuals with identified communication deficits
    - Manner in which strategies, interventions, and programs should be utilized throughout the day
    - Measurable objectives
  - Although number of Augmentative and Assistive Communication (AAC) devices had increased, they were not consistently available to the individuals and not consistently utilized by individuals.
  - Direct Support Professionals were not knowledgeable of the communication programs.

Habilitation, Training, Education, and Skill Acquisition Programs

The Facility had requested that the Monitoring Team's review focus upon ISPs and Skill Acquisition Programs (SAPs) that reflected procedures that had only recently been implemented. This limited the review to two ISPs and seven SAPs. Due to this small sample, any conclusions reached by the Monitor must be considered as provisional. Based on this limited review, it was not indicated that the Facility had substantially improved upon existing practices. In many areas, there were no appreciable improvements in the quality of ISPs or SAPs. Where improvement was noted, the change was modest.

- Improvements Needed
  - It was difficult to identify the process by which the IDT identified individual needs, determined priorities for intervention, and selected a formal intervention process or program. It was not evident that assessment data were thoroughly considered by the IDT. Furthermore, even when individual preferences were identified, the ISP reflected decisions counter to those preferences.
  - Many of the reviewed SAPs reflected a continuation of weaknesses noted during previous site visits. Although some form of task analysis was reflected in several programs, there was no evidence to suggest that the task analyses reflected individualized assessment. Instructions for staff tasked with implementing the SAPs were frequently lacking in specifics.

Most Integrated Setting

The Facility continued to make progress in encouraging and assisting individuals to move to more integrated settings. In particular, the Facility staff had continued to refer individuals for such movement. At the same time, many people remain on the referral list for an extended time.

- Positive Practices and Improvements Made
  - The outcome of increased referral and movement provides some indication that efforts to encourage movement have met with some success.
- Improvements Needed
  - The Facility needs to improve identification of supports needed and inclusion of those in the CLDP. This process needs to begin with improvement of identification of supports through the ISP planning process. Although the list of supports in the CLDP of the last individual who moved was more complete than for the others who moved, there still remained important supports that were not identified.
  - The development of the CLDP and listing of support needs must begin at the time of referral and be available throughout the process of selecting a more integrated setting and provider.
  - Although CLDPs were available at the time of transition, they were not available in time for review by the Local Authority, provider, individual, and LAR prior to the transition.

- The Facility had improved in providing educational activities for individuals, LARs, and staff, 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.
- 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.
- Because of the limited description of support needs in the CLDPs, it was difficult to assess the adequacy of the post-move monitoring visits. Observation of one visit identified some supports that were not checked as needed.

Consent

The State and Facility have made progress toward compliance with Provision U1 by establishing policy, and developing and revising a list that prioritizes individuals' need for guardianship and a process for ongoing semiannual review. Participation on the self-advocacy group is remarkable. Work still remains in implementing a structured means to assess capacity to make decisions, to obtain guardians when needed, and to develop skills of individuals in decision-making and self-advocacy.

- Positive Practices and Improvements Made
  - Prior to, and since, the last compliance visit, 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 to families and advocates to inform them.
  - The Facility has established remarkable participation by individuals in a self-advocacy group. Not only do more than 40% of individuals attend, but also participation by most attendees is active. In addition, the Facility was in process of working with the Arc to present a training session on self-advocacy to individuals residing at RGSC and to community advocates. A next step in evolution of the self-advocacy group would be to begin to teach and support individuals to take more leadership at meetings.
- Improvements Needed
  - Neither the Facility nor 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 the individual cannot make, or needs assistance to make, such decisions.
  - There is a need for more complete IDT review and discussion of individuals' need for rights restrictions with capacity to make such decisions being addressed in the discussions.
  - The Guardianship policy has not yet been fully implemented.

Recordkeeping and General Plan Implementation

The Facility had continued to make progress toward compliance, in terms of maintaining a unified record, auditing the record for compliance, making use of the records, and developing or revising policies needed to implement the Settlement Agreement. Improvements remain to be made in all provisions.

- Positive Practices and Improvements Made
  - The Unified Record contained all required components.
  - Records were in generally good condition, were accessible and secure, included most documents, and were legible.
  - Active records contained most required documents and few errors when compared to Appendix D requirements.
  - Policies guiding recordkeeping had been revised to address more clearly some of the requirements of Appendix D and to clarify processes to make records accessible.
  - The Facility had a robust records audit system that audited five or more records monthly. Inter-rater reliability was assessed for one record audit each month. Results of these audits showed progress toward having accurate and complete records. Corrective actions were identified and assigned for deficiencies in individual records, but systemic issues were not being addressed with systemic actions.
- Improvements Needed
  - Some documents (including assessments but also other crucial documents such as the Integrated Risk Review Form and Rights Assessments) were not in the Active Record, or were not current. There was no evidence that the Facility was addressing systemically the consistent absence of assessments and other documents or addressing gaps between entries.
  - The Share Drive provided a means to make records readily available. As with the paper records, many assessments were not posted timely to the Share Drive.
  - The Clinical Work Station (CWS) Integrated Progress Notes, which were organized chronologically by discipline, did not provide an easy way to tie clinical data together in a meaningful way to gain a clear and comprehensive picture of an individual's clinical status.
  - Observations by the Monitoring Team at IDT meetings indicated the Teams were not consistently using data to make decisions.
  - Both DADS and the Facility had continued to develop and revise policies but not all requirements of the Settlement Agreement have yet been addressed. The Facility needs to develop procedures to ensure staff are informed and understand newly developed and revised policies and that these policies are implemented accurately.

The comments in this executive summary were meant to highlight some of the more salient aspects of this status review of the Facility. The Monitoring Team hopes the comments throughout this report are useful to the Facility as it continues to work toward meeting the requirements of the Settlement Agreement.

| SECTION C: Protection from Harm-Restraints | |
|---|---|
| Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below. | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. RGSC Self-Assessment 8/13/12<br>2. RGSC Action Plan 8/9/12<br>1. RGSC Section C Presentation Book<br>2. DADS Policy 001-Use of Restraint 8/31/09<br>3. DADS Policy 001.1 Use of Restraint (4/10/12) and related training materials<br>4. RGSC SOP MR 700-14 The Use of Restraint (4/11)<br>5. RGSC SOP MR 200-02 Restrictive Practices (6/11)<br>6. RGSC SOP ICF-IID 200-02 Restrictive Practices (7/12)<br>7. RGSC SOP ICF-IID 400-16 Premedication for Medical and Dental Procedures (8/12)<br>8. RGSC SOP ICF-IID 500-07 Use of Mechanical Devices to Prevent Involuntary Self Injury and to Provide Postural Support (8/12)<br>9. Crisis intervention restraint documentation files prepared by the RGSC for Individuals #46, #61, and #77 (Sample C.1 eight restraint episodes)<br>10. Medical restraint records prepared by the RGSC for Individuals #15 and #139<br>11. Record reviews for Individuals #46, #61, and #77<br>12. Restraint Log 3/1/12 to 8/27/12<br>13. Restraint Trend Analysis 7/31/12<br>14. Incident Management Review Team (IMRT) Minutes reflecting Individual restraint review (4/3, 4/4, 4/6, 4/30, 5/1, 5/2, 5/23, 6/7, 6/11, 6/12, 6/13, 7/2, and 7/5, 2012)<br>15. IMRT Minutes reflecting restraint trends review (3/19, 4/17, 5/11, and 6/18, 2012)<br>16. Settlement Agreement Program Improvement Council (SA-PIC) minutes (2/29, 3/29, 4/26, 5/24, and 7/3/2012)<br>17. Training records for sample of staff<br>18. Training records for sample of restraint monitors<br>19. Dental Support Plans for Individuals #11, #93, #72, #31, and #98<br>20. Restraint Reduction Committee meeting minutes 3/15/12<br>**People Interviewed:**<br>1. Vanessa Villarreal, Associate Psychologist<br>2. Ten Direct Support Professionals<br>**Meetings Attended/Observations:**<br>1. Incident Management Review Team (IMRT) 8/27/12<br>2. Settlement Agreement Performance Improvement Council (SA-PIC) 8/28/12 |
| | **Facility Self-Assessment:** |

| | |
|---|---|
| | The Rio Grande self-assessment reported that the Facility was not in substantial compliance with five of seven provisions of this section of the Settlement Agreement (SA). The RGSC self- assessment reported substantial compliance with Provision C.2 and C.6.<br><br>The Facility's methodology for its self-assessment rating is described in each provision. For example, for Provision C.1, the Facility stated it reviewed 100% of restraints identified as for crisis intervention and provided an example of one that did not meet requirements of policy, therefore rating noncompliance. Information from the review of 100% of restraints also resulted in a rating of noncompliance for Provisions C.3 and C.8. In some instances the self-assessment methodology did not target each specific requirement of a Provision. This was particularly evident in C.8 where none of the key requirements of restraint review required in the Provision were assessed.<br><br>The Monitoring Team identified several problems that the self-assessment process did not discover. This suggests a need for more thoroughness in the self-assessment process. This was especially evident in the review of Provision C.1 with respect to restraint review documentation and C.5 with respect to medical monitoring of restraint.<br><br>The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. All of these action plans were described as "In Process." It appeared these action steps described activity that occurred since the last review. It was not possible to link deficiencies identified in the self-assessment to a related action plan step. One purpose of the self-assessment is to identify Facility practices that need improvement in order to reach compliance with various requirements of the SA. Flowing from this identification should be one or more action steps that are intended to improve Facility practices. This was not evident in the organization of data in the self-assessment and corresponding action plan.<br><br>Finally, the Facility prepared for the Monitoring Team a "Presentation Book" that is intended to display, for the most part, documentation that can validate work effort that substantiates compliance with specific elements of each Provision. Information and documents in the presentation book are not always organized and presented in a manner that accomplishes this objective. Doing so may help the Facility identify areas of compliance for which documentation is not present or is insufficient. |
| | **Summary of Monitor's Assessment:**<br>RGSC continued to make progress towards full compliance with this section of the Settlement Agreement. Overall, documentation on Restraint Checklists and Face to Face Assessment/Debriefing documents was much improved. While the number of crisis intervention restraints increased from that reported in the last review, restraint use is limited to a small number of Individuals. The Facility is working diligently on developing and enhancing programs that are intended to decrease use of restraint with these Individuals.<br><br>The Facility reported no use of medical restraint for dental procedures and limited use for medical procedures. Documentation related to medical restraints had improved from that observed at the last review; however, the Facility had done little to develop support plans to reduce reliance on medical |

| | |
|---|---|
| | restraint for those who still require it.<br><br>The rate of restraint use at RGSC, which was noted to have decreased significantly in the last review, continues to remain low even though the number of restraints has increased. This is the case with both crisis intervention and medical restraints. During this review period the use of crisis intervention restraint increased but was used with only four Individuals.<br><br>The administrative initiatives noted in previous 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.<br><br>Examples were identified in which restraints occurred that were not in accordance with applicable written policies, procedures, and plans governing restraint use. |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| C1 | Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used. | <u>Facility self-assessment:</u><br>The RGSC self-assessment reported lack of compliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs.<br><br>The Facility engaged in the following activities in conducting its self-assessment: reviewed Incident Management Review Team (IMRT) minutes for 21 of 21 (100%) restraints used in crisis intervention. Restraint reviews included review of the restraint checklist, physician orders, debriefing and face to face assessment for evidence of the individual posing an immediate and serious risk of harm to him/herself or others; less restrictive measures had been attempted without success; the restraint was not used for punishment, staff convenience, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use, and that approved restraint techniques were used .<br><br>Video reviews of emergency physical and chemical restraints, when video was available, were conducted by the Chief and/or Associate Psychologist. Reviews were conducted in order to determine if restraints were implemented in accordance with facility policy. Fourteen of 21 (66%) restraints were reviewed via video. Seven of 21 (34%) restraints were witnessed and underwent documentation review when video was not available.<br><br>From its self-assessment the Facility determined that: | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 1. All 21 (100% compliance) restraint checklists did not show any use of prone restraint, did not show that restraint was used for punishment, staff convenience, or in the absence of or as an alternative to treatment; were all in accordance with applicable, written policies, procedures, and plans governing restraint use; and were all conducted using approved restraint techniques.<br>2. One of 21 (5%) restraints, an emergency physical restraint occurring on 7/3/12, did not show that the individual was an imminent and serious risk of harm to self or others and did not show evidence of less restrictive measures being attempted without success.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because one of the 21 (5%) restraints used as crisis intervention was not in compliance with facility policy.<br><br><u>Monitoring Team findings:</u><br>The Facility had revised its restraint policy (RGSC SOP ICF-IID 700-14) to reflect the requirements of the revised State policy. This revised policy was effective as of July 1, 2012. As of the date of this review the Facility had not experienced restraint types or frequencies that would require use of some of the more substantive new requirements in the State policy such as an ISP Action Plan directed at reducing restraint use with a particular Individual, or a Protective Mechanical Restraint Plan. | |

| **Type of Restraint** | **Date range** |
|---|---|
| | 3/1/12 to 7/31/12 |
| Personal restraints (physical holds) during a behavioral crisis | 18 |
| Chemical restraints during a behavioral crisis | 3 |
| Mechanical restraints during a behavioral crisis | 0 |
| TOTAL restraints used in behavioral crisis | 21 |
| TOTAL individuals restrained in behavioral crisis | 4 |
| Of the above individuals, those restrained pursuant to a Crisis Intervention Plan | 0 |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | The use of crisis intervention restraint since the last review increased significantly. The Facility reported 21 instances of use of crisis intervention restraint from March 1, 2012 to July 31, 2012. In the five months prior to March the Facility reported two instances of use of crisis intervention restraint. Even though the Facility used restraint 21 times, there were only four Individuals for whom restraint was necessary. Many of the restraints associated with these four Individuals related to multiple restraints that occurred during a single behavioral episode when the restraints were essentially "back to back" and recorded as separate restraint episodes. For example, on the same day, restraint was used with Individual #77 at 3:09 pm, 3:22 pm, 3:35 pm, and 3:50 pm. Similarly, on the same day restraint was used with Individual #46 at 7:15pm, 7:24pm, and 7:34pm. Thus, seven of the 21 restraints (33%) actually involved only two episodes of behavior.<br><br>The Monitoring Team reviewed eight crisis intervention restraint episodes. This will be referred to as Sample C.1 throughout this report.<br><br>Use of medical restraint continued at a low rate. The Facility reported it did not use medical restraint for dental procedures and had no use of total intravenous anesthesia (TIVA). The Facility reported using medical restraint for medical procedures in three instances since the last review. The Monitoring Team reviewed two medical restraint episodes. This will be referred to as Sample C.2 throughout this report.<br><br>The Monitoring Team requested that documentation files be prepared for each instance of restraint in each sample that included at least the following:<br>• 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), ISP 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.<br>• Crisis Intervention Restraint – the restraint checklist, face to face debriefing documents, medical orders, physician specified monitoring schedule, standard facility protocol for monitoring chemical restraint (if applicable), documentation of review activity of the restraint episode, and any other information that would be helpful to the monitor in understanding the circumstances associated with the restraint use.<br><br>None of the individuals living at the RGSC had Safety Plans for Crisis Intervention (as defined in the previous State policy) or Individual Action Plans (as defined in the revised State policy). | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Prone Restraint<br>Based on Facility policy review, prone restraint is prohibited. Based on review of restraint records, restraint reduction committee minutes, staff interviews, and minutes of the Incident Management Review Team (IMRT), no use of prone restraint was identified or the subject of any discussion in meeting minutes. The Facility self-assessment included a review of video evidence of 14 of the 21 restraint episodes. This review did not detect any restraint use that could be construed as prone restraint.<br><br>Other Restraint Requirements<br>Based on document review, the Facility policy states that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment.<br><br>Additionally, this Provision requires that restraint use occur in accordance with applicable, written policies, procedures, and plans governing restraint use.<br><br>Restraint records were reviewed for Sample C.1 that included the restraint checklists, face-to-face assessment forms, debriefing forms, Individual Support Plan Addendums (ISPAs). 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:<br><br>In all eight restraint records reviewed (100%), 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."<br><br>The Facility, through its restraint review process, identified in its self-assessment one instance of use of restraint where the Individual's behavior did not appear to represent imminent and serious risk of harm to self or others. The Facility self-assessment also concluded that it did not appear less restrictive behavior management techniques were attempted without success prior to use of restraint. This was a six minute horizontal restraint of Individual #77 on 7/3/12. This restraint episode was not the subject of review by the Monitoring Team as it was not included in the Sample C.1.<br><br>The Monitoring Team met with 10 Direct Support Professionals (DSPs). All ten worked in an area where restraint use occurs. Five were from the morning shift and five from the afternoon shift. All were asked to respond to the question "From the training you've | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | received describe some strategies you would use with an Individual whose behavior may lead to restraint." Only six (60%) provided a response which was considered satisfactory by the staff person from the QA Department that evaluated staff responses. This apparent lack of staff knowledge may have prevented the use of potentially effective strategies in addressing behavior(s) that led to restraint use as reported in one instance in the Facility self-assessment.<br><br>From Sample C.1 the Monitoring Team identified three restraints (of eight – 38%) that occurred that were not in accordance with applicable written policies, procedures, and plans governing restraint use. Individual #46 was restrained three times (consecutively) on 6/6/12, the last of which was a chemical restraint. The Facility was unable to produce documentation which would validate that a Facility psychologist was consulted prior to the use of the chemical restraint. Additionally, the Facility was unable to produce documentation to validate that the use of the chemical restraint was reviewed (post restraint) by a psychiatrist and a pharmacist, as required by policy. These restraint episodes occurred within the timeframe of the self-assessment and the issues identified by the Monitoring Team should have been identified by the Facility either through its normal review process, or the self-assessment process which was reported as a "100% review of all restraints."<br><br>As described above, the Facility through its restraint review process, identified in its self-assessment one instance of use of restraint where the Individual's behavior did not appear to represent imminent and serious risk of harm to self or others, and it did not appear less restrictive behavior management techniques were attempted without success prior to use of restraint. Because of this the Monitoring Team cannot rule out that, in this instance, restraints may have been used for the convenience of staff, or as punishment, or not in a clinically justifiable manner.<br><br>Facility policies identified a list of approved restraints. Based on the review of Sample C.1 all restraints were policy approved.<br><br>This Provision is not in substantial compliance because of the issues described above associated with restraint use that were not in accord with applicable written policies, procedures, and plans governing restraint use. | |
| C2 | Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others. | <u>Facility self-assessment:</u><br>The RGSC self-assessment reported substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities in conducting its self-assessment: | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 1. 21 of 21 (100% of restraints as crisis intervention from 2/1/12 to 7/31/12) were reviewed by IMRT to determine if restraints were terminated as soon as the individual was no longer a danger to him/herself or others. Restraints were also reviewed in daily unit meetings and with IMRT. Restraint reviews included review of restraint checklist, physician orders, debriefing and face to face assessment.<br><br>2. Video reviews of emergency restraints, when video was available, were conducted by Chief and/or Associate Psychologist. Reviews were conducted in order to determine if restraints are implemented and terminated in accordance with facility policy.<br><br>From its self-assessment the Facility determined that<br>21 of 21 (100%) emergency restraints from 2/1/12 to 7/31/12 were reviewed. Monitoring indicated that 21 of 21 restraints were terminated as soon as the individual was no longer a danger to himself or others.<br><br>14 of 21 (66%) restraints were captured on video. 14 of 14 (100% of restraints reviewed on video) showed that the restraints were implemented and terminated in accordance to our policy.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance because 21 of 21 (100%) restraints used as a crisis intervention were terminated as soon the individual was no longer a danger to himself or others.<br><br><u>Monitoring Team findings:</u><br>The Facility provided documentation for all restraints in Sample C.1, which validated that restraint was terminated as soon as the individual was no longer a danger to him/herself or others. This consisted of the appropriate release code recorded on the Restraint Checklist, and, the appropriate "yes" response recorded on the Face-to-Face Assessment Debriefing (FFAD) question 2.6 "Restraint stopped when person restrained no longer a danger to self or others?" Additionally, in reviewing other restraint documentation the Monitoring Team did not find any evidence that would contradict the data reported on the Restraint Checklist and the FFAD. Finally, the Facility self-assessment reported it had conducted a 100% review of restraints, including video review of 67% of restraints (100% of those that occurred in areas covered by video surveillance cameras). This review concluded that restraint was terminated as soon as the individual was no longer a danger to him/herself or others in each instance.<br><br>This Provision is in substantial compliance. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| 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. | <u>Facility self-assessment:</u><br>The RGSC self-assessment reported non-compliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>1. Reviewed CTD training delinquency report for the following courses: PBS0100 - Positive Behavior Support, PMA0320 - PMAB Basic, PMA0400 - PMAB Restraint, PMA0700 - PMAB Prevention, and RES0105 - Restraint: Prevention and Rules for Use at MR Facilities. Reports were reviewed for both refresher and pre-service trainings.<br><br>2. Reviewed ICF IID Policy 700-14, Use of Restraint to ensure the policies indicated approved restraints and require that staff use only such approved restraints, and 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.<br><br>3. Reviewed 21 of 21(100%) restraint checklists to ensure approved restraints were implemented and least restrictive interventions were attempted without success.<br><br>From its self-assessment the Facility determined that CTD training delinquency report indicates that all direct care staff (100%) working with individuals had completed PBS0100 - Positive Behavior Support. Two direct care staff were deficient in PMAB0400, PMAB0700, and PMAB0320 refresher training, and three direct care staff were deficient in RES0105 refresher training.<br><br>1. Policy ICF-DD 700-14 was revised 06/12 and includes elements required for compliance with settlement agreement.<br><br>2. 1 of 21 restraints (7/3/12 - emergency physical restraint) did not show evidence of less restrictive measures being attempted without success.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because all direct care staff have not completed a competency based refresher training in three of the four required trainings: PMA0320 - PMAB Basic, PMA0400 - PMAB Restraint, PMA0700 -PMAB Prevention, and RES0105 - Restraint: Prevention and Rules for Use at MR Facilities. One restraint also showed that less restrictive measures were not implemented before restraint. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Monitoring Team findings:<br>The Facility's self-assessment of this provision did not include an assessment that restraint use was implemented according to policy. As described in Provisions C.1 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.<br><br>Review of the DADS training curricula used by the facility demonstrated that it included adequate training and competency-based measures in the following areas:<br>• Policies governing the use of restraint;<br>• Approved verbal and redirection techniques;<br>• Approved restraint techniques; and<br>• Adequate supervision of any individual in restraint.<br><br>RGSC SOP ICF IID 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:<br>• PBS0100 Positive Behavior Support<br>• PMA0320 PMAB Basic<br>• PMA0400 PMAB Restraint<br>• PMA0700 PMAB Prevention<br>• RES0105 Restraint: Prevention and Rules for Use at MR Facilities<br><br>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.<br><br>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 completed the course, as of the date the report is produced. For example, the report provided to the Monitoring Team was produced on 8/6/12. It reports that RGSC had 497 employees required to take ABU0100, Abuse, Neglect, Exploitation and that 99% of the 497 employees were current in this training. This report was not useful to the Monitoring Team for this review for two reasons. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • 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).<br>• Second, some data appeared to be obviously incorrect. For example, the report indicated 312 employees are required to take PMAB Basic but only 106 are required to take PMAB Restraint and PMAB Prevention. At a minimum all 156 Direct Support Professionals are required to take all three classes.<br><br>These issues were identified in the last report and have not been addressed. 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.<br><br>The Monitoring Team chose a random sample of 25 employees for review of training transcripts. This will be referred to as Sample C.3 throughout the report. Staff training transcripts for these 25 employees were reviewed with the following results:<br>• PBS0100 Positive Behavior Support: 20 of 25 (80%) had completed this training within the last 12 months.<br>• PMA0320 PMAB Basic: all 25 (100%) had completed this training within the last 12 months.<br>• PMA0400 PMAB Restraint: all 25 (100%) had completed this training within the last 12 months.<br>• PMA0700 PMAB Prevention: all 25 (100%) had completed this training within the last 12 months.<br>• RES0105 Restraint: Prevention and Rules for Use at MR Facilities: all 25 (100%) had completed this training within the last 12 months.<br><br>The Monitoring Team met with 10 Direct Support Professionals (DSPs). All ten worked in an area where restraint use occurs. Five were from the morning shift and five from the afternoon shift. All were asked to respond to the question "From the training you've received describe some strategies you would use with an Individual whose behavior may lead to restraint." Only six (60%) provided a response which was considered satisfactory by the staff person from the QA Department that evaluated staff responses. This apparent lack of staff knowledge may have prevented the use of potentially effective strategies in addressing behavior(s) that led to restraint use as reported in one instance in the Facility self-assessment. This also underscores the need to ensure all staff are current in PBS training.<br><br>As reported in Provision C.1 the Facility self-assessment identified one instance of restraint use that did not appear to meet the SA requirement that restraint can only be used after a graduated range of less restrictive measures had been exhausted or | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | considered in a clinically justifiable manner.<br><br>This Provision is not in substantial compliance. | |
| 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. | <u>Facility self-assessment:</u><br>The RGSC self-assessment reported lack of compliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>1. 21 of 21 (100% of restraints used as crisis intervention from 2/1/12 to 7/31/12) were reviewed by IMRT to determine if restraints were terminated as soon as the individual was no longer a danger to him/herself or others. Restraints were also reviewed in daily unit meetings. Restraint reviews included review of restraint checklist, physician orders, debriefing and face to face assessment.<br><br>2. 21 of 21 (100%) doctor's orders and ISP/ISPA's were reviewed for evidence of any documentation prohibiting the use of restraint.<br><br>3. 7 of 7 (100%) medical restraints were reviewed for ISP's regarding supports to eliminate need for restraint.<br><br>From its self-assessment the Facility determined that 21 of 21 (100%) of restraints used as crisis intervention did not show evidence that any restraint was used that was prohibited by the individual's medical orders or Interdisciplinary Team. 21 of 21 (100%) of doctor's orders and ISP/ISPA's reviewed did not show evidence of any documentation prohibiting the use of restraint. None of 7 (0%) medical restraints had ISP's containing information regarding supports to eliminate need for restraint.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because none of 7 (0%) medical restraints had ISP's with supports to help eliminate restraint.<br><br><u>Monitoring Team findings:</u><br>As reported in Provision C.1 the Facility self-assessment identified one instance of use of restraint that did not appear to be in response to crisis intervention. The Individual's behavior did not appear to represent imminent and serious risk of harm to self or others. The Facility self-assessment also concluded that it did not appear less restrictive behavior management techniques were attempted without success prior to use of restraint. This was a six minute horizontal restraint of Individual #77 on 7/3/12. This restraint episode was not the subject of review by the Monitoring Team as it was not included in the | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Sample C.1.<br><br>The Facility provided the Monitoring Team with a sample form entitled "Considerations for Implementing Restraint Chemical/Physical". Data recorded on this form would describe any medical or psychological conditions that should be considered in the context of restraint use with the specific Individual. It is to be completed (and signed) by the physician, and, reviewed (and signed) by the Individual's Qualified Developmental Disability Professional (QDDP). This process was developed by the Facility to ensure the SA requirement that "no restraint shall be used that is prohibited by the individual's medical orders or ISP" was met. The Facility was unable to provide documentation that would validate this process had been used during this review period. None of the restraint documentation files prepared by the Facility contained the referenced form, and on interview, the Section C lead reported the process is in the initial stages of implementation and that staff training had occurred in June. Therefore, the Monitoring Team could not determine whether any restraints used were prohibited by medical orders.<br><br>As reported in the Facility self-assessment, and validated by the Monitoring Team through interview, none of the Individuals for which medical restraint was used had supports in place to minimize or eliminate the need for restraint.<br><br>The Facility reported it had not used medical restraint for dental procedures since the last review. The administrative initiatives noted in previous compliance reports to support individuals in dental 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 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.<br><br>The Monitoring Team reviewed a small sample of Specific Program Objectives (SPOs) that had as a goal improving oral hygiene by increasing tolerance of dental treatment. Most plans involved rehearsals of a visit to the dentist. Data associated with those SPOs reviewed showed successful results. For example, Individual # 98, over the course of several weeks, began with only cooperating in sitting in the dental chair but graduated to allowing tooth brushing.<br><br>Specific issues associated with the Facility's failure to identify and document medical contradictions for restraint use are presented in Provision L.1 of this report, including an | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Individual that was reported to have no contraindication for restraint but had a diagnosis of congenital hip dysplasia and osteoporosis, and an Individual that was reported to have no contraindication to restraint but was suspected of having cardiomyopathy, and a diagnosis of seizure disorder and hypertension. For both Individuals these conditions suggest restraint restrictions should have been carefully considered by the IDT, summarized in the ISP, and communicated to relevant staff.<br><br>The Facility had only recently initiated the process to ensure the SA requirement that "no restraint shall be used that is prohibited by the individual's medical orders or ISP" was met therefore this Provision is not in substantial compliance. Additionally, none of the Individuals for which medical restraint was used had supports in place to minimize or eliminate the need for restraint.<br><br>This Provision is not in substantial compliance. | |
| C5 | Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional | <u>Facility self-assessment:</u><br>The RGSC self-assessment reported lack of compliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>1. 21 of 21 (100% of restraints as crisis intervention) were reviewed by Incident Management Review Team from 2/1/12 to 7/31/12 for evidence of face-to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint, for monitoring and documentation of vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order, an alternative monitoring schedule as ordered by the physician, and for restraints that occurred away from a SSLC. Restraint reviews include a review of the restraint checklist, physician orders, debriefing and face to face assessment.<br><br>2. Physicians' orders were reviewed for 21 of 21 (100%) crisis intervention restraints.<br><br>3. 7 of 7 (100%) medical restraints were reviewed for documentation by physician on schedule and type of monitoring required.<br><br>4. 7 of 7 (100%) doctor's orders were reviewed for documentation by physician on schedule and type of monitoring required.<br><br>From its self-assessment the Facility determined that it was unable to assess the requirement for 30 minute checks of vital signs and mental status as none of 21 (0%) | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 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. | emergency restraints lasted 30 minutes. 21 of 21 (100%) crisis intervention restraints occurred on campus. 21 of 21 (100%) face to face assessments were completed within 15 minutes by the restraint monitor.<br><br>1. 0 of 7 (0%) physicians' orders for medical restraint specified the type of monitoring required.<br><br>2. 0 of 7 (0%) medical restraints showed evidence of documentation by physician on schedule and type of monitoring required.<br><br>3. 0 of 7 (0%) doctors' orders showed evidence of documentation by physician on schedule and type of monitoring required.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because monitoring schedule of at least 30 minutes was not specified in 28 of 28 (0% compliance) medical/emergency restraints and doctor's orders.<br><br><u>Monitoring Team findings:</u><br>Since the last review the Facility had made improvement in restraint documentation required to be completed by restraint monitors. The Facility's self-assessment process had also improved and appeared to more accurately detect compliance-related documentation deficiencies.<br><br>Review of Facility training documentation showed that there were adequate training curricula on the application and assessment of restraint. Training provided to Restraint Monitors by the Associate Psychologist 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 was noticeably improved from that observed at the last review. For the most part, FFADs reviewed in Sample C.1 did not contain substantive documentation errors or inconsistencies.<br><br>The Facility provided the Monitoring Team with a list of staff designated as Restraint Monitors. Six were selected for review of training requirements. Three of the six were selected because they were the only staff performing restraint monitor duties since the last review.<br><br>RGSC restraint policy requires that restraint monitors complete the following training:<br>1. PBS0100 Positive Behavior Support<br>2. PMA0320 PMAB Basic<br>3. PMA0400 PMAB Restraint<br>4. PMA0700 PMAB Prevention | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 5. RES0105 Restraint: Prevention and Rules for Use at MR Facilities<br>6. CPR0100 Basic<br>7. RIG0100 Rights of Consumers<br>8. ABU0100 Abuse and Neglect<br><br>All classes were to be taken pre-service and every 12 months thereafter. In addition, Restraint Monitors were to successfully complete training conducted by the Psychology Department on conducting and documenting the face-to-face assessment and debriefing. This training included a Restraint Monitor Competency Check which all six restraint monitors in the sample successfully completed. All six restraint monitors had completed all required training.<br><br>All eight restraint documentation files contained an FFAD. For the most part all were completed correctly and accurately reflected the restraint episode as recorded on the Restraint Checklist.<br><br>Documentation associated with completing an adequate assessment of the circumstances of the restraint needs to improve. There were brief entries in section 3 of the FFAD. Occasional notations in other parts of the FFAD sometimes also addressed this topic. 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, ISP, and daily schedule. Some of this information was contained in some of the ISPA and IMRT meetings that reviewed the restraint episode but this was not consistent. This component of this provision of the SA requires a level of review by the restraint monitor who arrives within 15 minutes that should be more substantive than what was typically recorded on the FFADs and other documentation reviewed by the Monitoring Team.<br><br>None of the crisis intervention restraint records in the sample indicated an alternative physician-ordered monitoring schedule.<br><br>Based on a review of eight restraint records for restraints that occurred at the Facility (Sample C.1), there was documentation that a licensed health care professional:<br>• Conducted monitoring at least every 30 minutes for physical restraints and every 15 minutes for chemical restraints from the initiation of the restraint in five (62%) of the instances of restraint. Instances where this did not occur were:<br>o Individual #77: On 6/12/12 at 3:09 p.m., the Individual was physically restrained.<br>o Individual #77: On 6/12/12 at 3:50 p.m., the Individual was physically restrained.<br>o Individual #46: On 6/6/12 at 7:34 p.m., the Individual received a | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | chemical restraint (Ativan 2 mg intramuscularly). He was not monitored consistently every 15 minutes as required by policy during some monitoring for approximately three hours.<br>• Monitored and documented vital signs in three (38%). Records that did not contain documentation of this, or for which documentation was not fully adequate, included:<br>o Individual #77: On 6/12/12 at 3:09 p.m., the Individual was physically restrained.<br>o Individual #77: On 6/12/12 at 3:50 p.m., the Individual was physically restrained.<br>o Individual #77: On 6/12/12 at 3:22 p.m., the Individual was physically restrained There was documentation that the nurse attempted to take the Individual's vital signs every 30 minutes but he refused to allow them taken.<br>o Individual #77: On 6/12/12 at 3:35 p.m., the Individual received a chemical restraint. The nurse documented that Individual #77 refused to allow vital signs taken every 15 minutes.. There was documentation that the nurse made mental status observations that Individual #77 was alert and agitated but refused to allow vital signs. Although the individual refused to allow vital signs taken, the nurse should have been able to document whether or not the Individual was experiencing possible signs of distress, e.g., problems with respiration or other indicators of distress.<br>o Individual #46: On 6/6/12 at 7:34 p.m., the Individual received a chemical restraint (Ativan 2 mg). Vital signs were not consistently taken every 15 minutes as required by policy. However, vital signs were taken for approximately three hours. Although the individual refused to allow vital signs taken, the nurse should have been able to document whether or not the Individual was experiencing possible signs of distress, e.g., problems with respiration or other indicators of distress.<br>• Monitored and documented mental status in six (75%). Records that did not contain documentation of this included:<br>o Individual #77: On 6/12/12 at 3:09 p.m.<br>o Individual #77: On 6/12/12 at 3:50 p.m.<br><br>The Monitoring Team noted documentation on the Restraint Checklists of numerous refusals by the Individuals to allow the nurses to complete the required vital signs monitoring. In the future, if an individual frequently refuses to allow the nurses to complete the required monitoring, this may indicate a need to do something different with the ISP, skill acquisition plan, or safety plan. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Based on documentation provided by the Facility, zero restraints had occurred off the grounds of the Facility in the last six months<br><br>Sample C.2 was selected from the list of individuals who had medical restraint since the last review. It represents two of the seven 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:<br>• One contained documentation that the physician specified the schedule and type of monitoring required.<br>• None indicated an alternative monitoring schedule or type ordered by the physician.<br>• All seven incidents of medical restraint were chemical restraint.<br>• Both included a physician order specific to the medical/dental procedure for the chemical restraint.<br><br>This Provision is not in substantial compliance. | |
| C6 | Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be | <u>Facility self-assessment:</u><br>The RGSC self-assessment reported compliance with this provision of the Settlement Agreement (SA). The Monitoring Team does not concur.<br><br>The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>1. 21 of 21 (100% of restraints used as crisis intervention) were reviewed by Incident Management Review Team from 2/1/12 to 7/31/12 for documentation of restraint-related injury; opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan, documentation 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 proper documentation.<br><br>2. Video reviews of crisis intervention restraints, when video was available, were conducted by the Chief and/or Associate Psychologist. Reviews were conducted in order to determine if restraints are implemented in accordance with facility policy.<br><br>3. Review seven of seven (100%) medical restraints for documentation of continuous one-to-one supervision. six of seven (86%) medical restraints resulted in premedication.<br><br>4. Random Interviews with three supervisors, two nursing staff and two direct care | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | documented consistent with Appendix A. | staff were conducted in the month of June to determine the level of supervision during medical restraint.<br><br>From its self-assessment the Facility determined that:<br><br>1. In 21 of 21 (100%) physical holds, two staff and a restraint monitor were present providing 1:1 supervision of individuals placed in physical holds for the duration of hold from 2/1/12 to 7/31/12. These individuals are documented on the restraint check-list. Unable to assess requirement to receive opportunities to exercise restrained limbs, eat near meal times, etc. as no physical restraint lasted longer than 15 minutes.<br>2. A total of 14 of 21 (66%) of the restraints episodes were captured on video. 100% of the episodes that were reviewed indicated that the restraints were implemented in accordance to our policy.<br>3. In six of seven (86%) medical restraints, individuals received premedication. All seven (100%) medical restraints showed evidence of documentation of continuous 1:1 supervision.<br>4. Interviews with nursing staff , shift supervisors and direct support staff indicated that any individual receiving premedication is placed on 1:1 supervision until discontinued by nursing (when effects of medication have worn off).<br><br>Based on the findings of the self-assessment, the Facility determined that this provision was in substantial compliance due to the evidence supporting required supervision being in place.<br><br><u>Monitoring Team findings:</u><br>A sample (Sample C.1) of eight Restraint Checklists for individuals in crisis intervention restraint was selected for review. The following compliance rates were identified for each of the required elements:<br>• In eight (100%), continuous one-to-one supervision was documented.<br>• In eight (100%), the date and time restraint was begun was documented.<br>• In eight (100%), the location of the restraint was documented.<br>• In eight (100%), information about what happened before, including the change in the behavior that led to the use of restraint was adequately documented.<br>• In eight (100%), the interventions taken by staff prior to the use of restraint were adequately documented and are adequate for post restraint review.<br>• In eight (100%), the specific reasons for the use of the restraint were adequately documented.<br>• 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 | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | use of restraint was apparent in all eight (100%) cases.<br>• In eight (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated on the restraint checklist.<br>• In eight (100%), the names of staff involved in the restraint episode were indicated on the restraint checklist.<br><br>The Restraint Checklist documented observations of the individual and actions taken by staff while the individual was in restraint, including:<br>• All eight were of short duration. None required observations at least every 15 minutes. For two of the Individuals (involving seven of the eight restraints) the restraints occurred "back to back to back." In these instances the specific behaviors of the individual that required continuing restraint were noted.<br>• 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.<br>• In eight (100%), the level of supervision provided during the restraint episode was recorded on the restraint checklist.<br>• In eight (100%), the date and time the individual was released from restraint was recorded on the restraint checklist.<br>• In four (50%), 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. This was not documented on the Restraint Checklist for the four restraints of Individual #77.<br>• In eight records (100%) restraint debriefing forms (FFADs) had been completed.<br>• Crisis intervention chemical restraint of Individuals #46 and #77 was included in Sample C.1. The documentation for each restraint did not include an "Administration of Chemical Result Consult" required by policy. The documentation of chemical restraint of Individual #46 did not include the required "Chemical Restraint Clinical Review" which is part of the FFAD process. The documentation of chemical restraint of Individual #77 did include the required "Chemical Restraint Clinical Review", although this review was not completed until two weeks after the chemical restraint occurred.<br><br>The Facility demonstrated significant improvement towards achieving compliance with this Provision. There are still issues which need to be addressed, primarily with medical staff. As a result, this Provision is not in substantial compliance. | |
| C7 | Within six months of the Effective Date hereof, for any individual | According to Facility documentation, during the six-month period prior to the on-site review, a total of two individuals were placed in restraint more than three times in any | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall: | rolling thirty-day period. A sample of two of these individuals (100%) was selected for review to determine if the requirements of the Settlement Agreement were met.<br><br>The following documents were reviewed<br>• PSPs,<br>• PST addenda,<br>• PBSPs,<br>• PBSP progress notes,<br>• Restraint documentation<br>• Psychological Evaluations and Updates<br><br>The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement.<br><br>For two of the individuals/instances reviewed (100%), individuals' teams met to discuss the restraints. | |
| | (a) review the individual's adaptive skills and biological, medical, psychosocial factors; | <u>Facility self-assessment:</u> The RGSC self-assessment reported compliance with this provision of the Settlement Agreement (SA). The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>1. 21 of 21 (100% of restraints used as crisis intervention) were reviewed by Incident Management Review Team from 2/1/12 to 7/31/12 for restraint documentation for individuals who had more than three restraints in thirty days. Restraint reviews include a review of restraint checklist, physician orders, debriefing and face to face assessment.<br><br>2. 6 of 6 (100%) ISPA's for individuals placed in restraint more than three times in a rolling 30 day period were reviewed for Individual #1 dated (4/30/12, 5/23/12, 6/12/12, and 6/14/12) and Individual #2 dated 6/13/12 and 7/5/12) for possible contributing environmental factors.<br><br>From its self-assessment the Facility determined that:<br>1. Of the four individuals placed in emergency restraint from 2/1/12 to 7/31/12, two individuals of (50%) who had been placed in restraint had been restrained more than three times in a thirty day period. Individual #1 (4/2/12, 4/3/12, 4/26/12, 4/27/12) and again (5/22/12, 6/9/12, 6/9/12, and 6/12/12). Individual #2 (6/12/12, 6/12/12, 6/12/12, 6/12/12, and 7/3/12). | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 2. Six of six (100%) ISPAs reviewed showed evidence of review of the possibly contributing environmental conditions.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision was in substantial compliance due to the evidence supporting review of contributing environmental conditions in the ISPA's.<br><br><u>Monitoring Team findings</u>:<br>For none of the individuals/instances reviewed (0%), individuals' teams reviewed the individual's adaptive skills.<br><br>The following are examples of where teams failed to do this adequately:<br>• For neither Individual #61 nor Individual #77, did documentation of any restraint review reflect that the IDT reviewed adaptive behavior assessments or discussed current adaptive strengths and weaknesses.<br><br>For two of the individuals/instances reviewed (100%), individuals' teams reviewed the biological, medical and psychosocial factors. The following are example of individuals who whom this was done appropriately:<br>• For Individual #61, documentation of restraint reviews reflected that the IDT had discussed the failure of staff to implement fluid restrictions. This failure, and the potential decrease in sodium levels for the Individual, was identified as a potential contributing factor in the behavior that prompted the use of restraint. The IDT also reviewed recent medical conditions and changes in psychotropic medication.<br>• For Individual #77, documentation of restraint reviews reflected that the IDT had discussed psychotropic medications, potential cardiac conditions, and personal limitations in independent ambulation. | |
| | (b) review possibly contributing environmental conditions; | <u>Facility self-assessment:</u> The RGSC self-assessment reported compliance with this provision of the Settlement Agreement (SA). The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>1. 21 of 21 (100% of restraints as crisis intervention) were reviewed by Incident Management Review Team from 2/1/12-7/31/12 for restraint documentation for individuals who had more than three restraints in thirty days. Restraint reviews included a review of restraint checklist, physician orders, debriefing and face to face assessment.<br><br>2. Six of six (100%) ISPA's for individuals placed in restraint more than three times in a | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | rolling 30 day period were reviewed for Individual #1 and Individual #2 for possible contributing environmental factors.<br><br>From its self-assessment the Facility determined that:<br>1. Of the four individuals placed in emergency restraint from 2/1/12 to 7/31/12, two (50%) who had been placed in restraint had been restrained more than three times in a thirty day period.<br>2. Six of six (100%) ISPAs reviewed showed evidence of review of the possibly contributing environmental conditions.<br><br>Based on the findings from this self-assessment, this provision was in substantial compliance due to the evidence supporting review of contributing environmental conditions in the ISPAs.<br><br><u>Monitoring Team findings</u>:<br>For two of the individuals/instances reviewed (100%), individuals' teams reviewed the possibly contributing environmental conditions. The following are examples of individuals for whom this was done appropriately:<br>• For Individual #61, documentation reflected that the IDT had discussed the relationship between 1:1 supervision and the attention-seeking behavior. It was presented during the discussion that the Individual could have engaged in behavior requiring restraint as a means to satisfy a desire for attention.<br>• For Individual #77, the IDT reviewed video that revealed staff surrounding the individual prior to the use of restraint. Documentation reflected that staff approaching the individual too closely could elicit behavior requiring restraint. | |
| | (c) review or perform structural assessments of the behavior provoking restraints; | <u>Facility self-assessment:</u> The RGSC self-assessment reported noncompliance with this provision of the Settlement Agreement (SA). The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>1. 21 of 21 (100% of restraints as crisis intervention) were reviewed by Incident Management Review Team from 2/1/12-7/31/12 for restraint documentation for individuals who had more than three restraints in thirty days. Restraint reviews include a review of restraint checklist, physician orders, debriefing and face to face assessment.<br><br>2. Review two of two individuals who were placed in restraint more than three times in a rolling thirty day period had current structural and functional assessments that addressed challenging behavior that initiated restraints.<br><br>From its self-assessment the Facility determined that: | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 1. Of the four individuals placed in emergency restraint two had been placed in restraint more than three times in a thirty day period. Both had structural assessments identifying challenging behavior that initiated restraint.<br><br>2. Both structural and functional assessments were reviewed, although there was no documentation that this occurred. No new structural and functional assessments were completed for the two individuals who were placed in restraint more than three times in a rolling thirty day period.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance due to the fact that there was no evidence to document the review of structural assessments of the behavior provoking restraints.<br><br><u>Monitoring Team findings</u>:<br>For two of the individuals/instances reviewed (100%), individuals' teams reviewed and/or performed structural assessments of the behavior provoking restraints. The following are examples of individuals for whom structural assessments were done:<br>• For both Individuals #61 and #77, restraint review documentation reflected that the most recent Structural and Functional Assessment (SFA) was discussed. It was not clear, however, that either SFA was adequate in regard to the behavior resulting in restraint. For Individual #61, the SFA had not been reviewed or updated since September 2011. For Individual #77, the most recent SFA was completed in January of 2011. More recent assessments would be needed to identify current factors that may affect the behaviors provoking restraints. | |
| | (d) review or perform functional assessments of the behavior provoking restraints; | <u>Facility self-assessment:</u> The RGSC self-assessment reported noncompliance with this provision of the Settlement Agreement (SA). The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>1. 21 of 21 (100% of restraints as crisis intervention) were reviewed by Incident Management Review Team for restraint documentation for individuals who had more than three restraints in thirty days. Restraint reviews included a review of restraint checklist, physician orders, debriefing and face to face assessment.<br><br>2. Both individuals who were placed in restraint more than three times in a rolling thirty day period had current structural and functional assessments that addressed challenging behavior that initiated restraints.<br><br>From its self-assessment the Facility determined that:<br><br>Both Individuals placed in restraint more than three times in a rolling 30 day period had | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | structural assessments identifying challenging behavior that initiated restraint.<br><br>Both structural and functional assessments were reviewed, although there was no documentation that this occurred. No new structural and functional assessments were completed for the two individuals who were placed in restraint more than three times in a rolling thirty day period.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance due to the fact that no evidence that structural and functional assessments were reviewed for the two individuals who were placed in restraint more than three times in a rolling thirty day period.<br><br><u>Monitoring Team findings</u>:<br>For two of the individuals/instances reviewed (100%), individuals' teams reviewed and/or performed functional assessments of the behavior provoking restraints. The following are examples of individuals for whom functional assessments were done:<br>• For both Individuals #61 and #77, restraint review documentation reflected that the most recent Structural and Functional Assessment (SFA) was discussed. It was not clear, however, that either SFA was adequate in regard to the behavior resulting in restraint. For Individual #61, the SFA had not been reviewed or updated since September 2011. For Individual #77, the most recent SFA was completed in January of 2011. This SFA identified the function of the target behavior to be escape from attention, but included using attention and verbal praise as reinforcement for replacement behavior. | |
| | (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 | <u>Facility self-assessment:</u><br>The RGSC self-assessment reported noncompliance with this provision of the Settlement Agreement (SA). The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>1. 21 of 21 (100% of restraints as crisis intervention) were reviewed by Incident Management Review Team for restraint documentation for individuals who had more than three restraints in thirty days. Restraint reviews included a review of restraint checklist, physician orders, debriefing and face to face assessment.<br><br>2. Reviewed PBSP's for the two individuals who were restrained more than 3 times in a 30 day period to ensure they were based on that individual's particular strengths, they objectively defined the 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, the type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP; | 3. All ISPA's for individuals placed in restraint more than three times in a rolling 30 day period were reviewed for Individual #1 and Individual #2 for a service plan.<br><br>From its self-assessment the Facility determined that:<br>1. The PBSP's for both Individuals showed evidence of documented strengths, type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint. Both PBSP's had objectively defined target behaviors that lead to the use of the restraint and alternative, positive, adaptive replacement behaviors.<br><br>2. None of six (100%) ISPA's for individuals placed in restraint more than three times in a rolling 30 day period showed evidence of a service plan indicating type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because no PBSP's showed evidence of documented strengths, type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint and no service plan was designed for either individual.<br><br><u>Monitoring Team findings</u>:<br>For two of the individuals reviewed (100%), the individual had a PBSP. Of the two individuals in the sample who had PBSPs, the following was found:<br>• 1 (50%) was based on the individual's strengths;<br>• Two (100%) specified the objectively defined behavior to be treated that led to the use of the restraint;<br>• None (0%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint; and<br>• None (0%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint.<br><br>The following are examples of inadequacies in the PBSPs:<br>• For Individual #61, the most recent PBSP was implemented in September, 2011. Although both physical aggression and self-injury had increased since the PBSP was implemented, the PBSP had not been revised.<br>• For Individual #77, the most recent PBSP had been implemented in October 2011 and was based upon an SFA completed in January 2011. The stated treatment expectations of the program were met in January 2012. Despite | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | increases in behavior resulting in restraint, neither the SFA nor the PBSP were reviewed specifically to determine the need for revision. | |
| | (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 | Facility self-assessment: The RGSC self-assessment reported noncompliance with this provision of the Settlement Agreement (SA). The Facility reported it had engaged in the following activities in conducting its self-assessment:<br><br>1. 21 of 21 (100% of restraints as crisis intervention) were reviewed by Incident Management Review Team for restraint documentation for individuals who had more than three restraints in thirty days. Restraint reviews include a review of restraint checklist, physician orders, debriefing and face to face assessment.<br><br>2. Created a treatment integrity/inter-observer agreement process to help access effectiveness of plan and its implementation.<br><br>From its self-assessment the Facility determined that Integrity checks were not consistently completed across all ICF program settings due to shortage of staff.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial<br>due to continued need to implement treatment integrity checks in order to ensure supports are consistently present as outlined by the individuals' plan.<br><br>Monitoring Team findings:<br>Treatment integrity checks were not completed for the PBSPs written for either individual reviewed. Therefore, the Facility did not determine that the treatment plan was implemented accurately and consistently. | Noncompliance |
| | (g) as necessary, assess and revise the PBSP. | Facility self-assessment: The RGSC self-assessment reported noncompliance with this provision of the Settlement Agreement (SA). The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>1. 21 of 21 (100% of restraints as crisis intervention) were reviewed by Incident Management Review Team for restraint documentation for individuals who had more than three restraints in thirty days. Restraint reviews include a review of restraint checklist, physician orders, debriefing and face to face assessment.<br><br>2. Six of six (100%) ISPA's for individuals placed in restraint more than three times in a rolling 30 day period were reviewed for Individual #1 and 06/14/2012) and Individual #2.<br><br>3. Two of two (100%) PBSP's were reviewed to see if a revision was necessary. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | From its self-assessment the Facility determined that:<br><br>1. One of six (17%) ISPA's for individuals placed in restraint more than three times in a rolling 30 day period made reference to the individuals PBSP.<br><br>2. Two of two (100%) PBSP's were assessed and both had Positive Behavior Support Plans that targeted challenging behavior that initiated restraint.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because due to the fact that there is no evidence the PBSP's were reviewed and assessed for revision and only one (17%) ISPA contained information related to PBSP review.<br><br><u>Monitoring Team findings</u>:<br>In none of the records reviewed (0%), there was documentation that the individual's PBSP had been revised as appropriate.<br><br>The following are examples of where teams failed to do this adequately:<br>• For Individual #61, the most recent PBSP was implemented in September, 2011. Although both physical aggression and self-injury had increased since the PBSP was implemented, the PBSP had not been revised.<br>• For Individual #77, the most recent PBSP had been implemented in October 2011 and was based upon an SFA completed in January 2011. The stated treatment expectations of the program were met in January 2012. Despite increases in behavior resulting in restraint, neither the SFA nor the PBSP were reviewed specifically to determine the need for revision. | |
| 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. | <u>Facility self-assessment:</u><br>The RGSC self-assessment reported noncompliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>1. Review of Incident Management Review Team (IMRT) minutes for 21 of 21 (100%) of restraints used as a crisis intervention. Restraint reviews included review of restraint checklist, physician orders, debriefing and face to face assessment for evidence of the individual posing an immediate and serious risk of harm to him/herself or others; less restrictive measures have been attempted without success; the restraint was not used for punishment, staff convenience, or in the | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use, and that approved restraint techniques were used .<br><br>2. Video reviews of emergency physical and chemical restraints, when video is available, were conducted by Chief and/or Associate Psychologist. Reviews are conducted in order to determine if restraints are implemented in accordance with facility policy. Review video footage of crisis intervention restraint on 7/3/12.<br><br>From its self-assessment the Facility determined that:<br><br>1. None of 21 (0%) restraint checklists showed any use of prone restraint, did not show that restraint was used for punishment, staff convenience, or in the absence of or as an alternative to treatment; were all in accordance with applicable, written policies, procedures, and plans governing restraint use; and were all conducted using approved restraint techniques.<br><br>2. 14 of 21 (66%) restraints were reviewed via Video. Seven of 21(34%) restraints underwent documentation review when video was not available.<br><br>3. One of 21(5%) restraints (7/3/12 - emergency physical restraint) did not show that the individual was an imminent and serious risk of harm to himself or others and did not show evidence of less restrictive measures being attempted without success.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because one of the 21 (5%) restraints used as a crisis intervention was not in compliance with facility policy.<br><br><u>Monitoring Team findings:</u><br>The RGSC self-assessment reported lack of compliance with this provision of the SA. This was because one episode of restraint was implemented without meeting all policy requirements. The RGSC self-assessment did not address the key requirements of this provision, that being that the circumstances under which restraint occurred are ascertained and a determination is made as to whether or not the circumstances suggest that it would be appropriate to revise the Individuals ISP, and, that this review occurs within three business days.<br><br>The RGSC had a process for restraint review but the Monitoring Team was unable in most | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | cases to validate its completeness or accuracy. For example, Individual #46 was restrained three times in one day "back to back to back." Only one of the three Restraint Checklists recorded the date of unit review. All three FFADs recorded the date of Unit Review but none contained the name or signature of the Unit Director or designee as required. All three FFADs recorded the date of IMRT review but the signature validating the review was a staff person from the Psychology Department, not the chair of the IMRT. The Chair of the IMRT is presumably the individual that would be viewed as accountable for reporting discussion and decisions of the group. The IMRT minutes provided to the Monitoring Team to demonstrate compliance only noted "one personal restraint and one chemical restraint" (not three) and noted the IDT will be meeting to review the restraint. From the documentation presented, the Monitoring Team could not validate that the IMRT "ascertained the circumstances under which restraint was used". The ISPA recording the IDT meeting reflected considerable discussion, including a review of previous behavioral episodes and a determination to continue 1:1 supervision and to increase medication. From this documentation, the Monitoring Team could not validate that the IDT "ascertained the circumstances under which restraint was used" as required by this Provision.<br><br>The Facility had a defined process for restraint review. It begins with a FFAD done by a restraint monitor immediately after the restraint episode. The restraint episode is to be reviewed in the unit morning meeting the next business day with whatever information had been available by the time of the meeting. It is to be reviewed that same day by the IMRT, often based on verbal reports from staff, either the Unit Director, Psychology Manager, or both. The restraint episode is to be 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 IDT for ISP revisions. Documentation provided to the Monitoring Team to validate these steps was not always apparent.<br><br>A Corrective Action Plan (CAP) related to a restraint episode reviewed at an IMRT meeting may be initiated. When this occurs the CAP is tracked by the Incident Management Coordinator using the database developed for this purpose. CAPs are tracked until closed, meaning the intended corrective action(s) have occurred and documentation to substantiate this has been presented.<br><br>Documentation of these reviews is contained in IMRT meeting minutes but, as described above, the minutes do not always contain sufficient information to document 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 | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | documented in an Individual Support Plan Addendum (ISPA) that becomes part of the permanent record.<br><br>The documentation provided to the Monitoring Team does not always provide data sufficient to validate the steps in the above described process had occurred.<br><br>This Provision is not in substantial compliance. | |

**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.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.3, C.4, C.5, C.6, and C.8).
3. Ensure all required staff training occurs and that it results in improved staff knowledge (Provision C.1 and C.3)
4. Improve procedures related to medical restraint and document accordingly (Provisions C.4, C.5 and C.6)
5. Improve the restraint review process to be more substantive and document accordingly (Provision C.8).
6. 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:**<br>**Documents Reviewed:**<br>1. RGSC Self-Assessment 8/13/12<br>2. RGSC Action Plan 8/9/12<br>3. RGSC Section D Presentation Book<br>4. RGSC SOP ICFMR 200-08 Protection from Harm – Abuse, Neglect, and Exploitation (revision date 1/12)<br>5. RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation (revision date 7/12)<br>6. RGSC SOP ICFMR 200-03 Incident Management (revision date 1/12)<br>7. RGSC SOP QM 100-025 Incident Management (revision date 4/12, replaced ICFMR 200-03)<br>8. RGSC SOP ICFDD 400-01 Injuries to Consumers (revision date 9/14/11)<br>9. RGSC SOP ICF-IID 400-01 Injuries to Consumers (revision date 7/12)<br>10. DADS Policy 2.1 Protection From Harm - Abuse, Neglect, and Exploitation 5/11/11<br>11. DADS Policy 2.2 Incident Management 1/31/11<br>12. Poster used to inform staff, individuals, LARs, and visitors of A/N reporting responsibilities and related monitoring reports from 3/12 to 7/12<br>13. Criminal Background Check Due Diligence Report from DADS (9/11)<br>14. Training transcripts of Facility and Department of Family Protective Services (DFPS) investigators<br>15. DFPS Investigator Training Outlines and Competency Tests (undated)<br>16. Acknowledgement of Responsibility for Reporting Abuse, Neglect, and Exploitation forms for sample of 25 employees<br>17. RGSC Unusual Incident Investigation Review Checklist (11/24/10)<br>18. Incident Management Tracking Log 3/1/12 to 8/27/12<br>19. List of Peer caused injuries 3/1/12 to 8/27/12<br>20. Witnessed Injury Log 3/1/12 to 8/27/12<br>21. Discovered Injury Log 3/1/12 to 8/27/12<br>22. Unusual Incident Log 3/1/12 to 8/27/12<br>23. Serious Injury Log 3/1/12 to 8/27/12<br>24. DFPS Investigation Case Log 3/1/12 to 8/27/12<br>25. OIG Investigation case Log 3/1/12 to 8/27/12<br>26. DFPS Investigative Reports and related documents for cases 41697292, 41850053, 42162903, 42313992, 42335905, and 42346363<br>27. Other DFPS case reports for 41537373, 41584512, 42031752, 41690732, and 42038659<br>28. Ten DFPS Administrative Referrals<br>29. OIG Investigations 889112, 862712, 889212, and 895512<br>30. Facility investigations for non-serious discovered injuries for Individuals #60 (7/27/12), #94(7/22/12), #63 (7/21/12 ), #1 (7/26/12, #5 (7/27/12) and #48 (7/13/12) |

| | |
|---|---|
| | 31. Facility investigations for serious injuries and incidents UIRs 12-013, 016, and 017<br>32. Other UIRS: 001, 086, 089, 105, and 106<br>33. Material used to educate guardians on abuse reporting (2/12)<br>34. Sample documentation of employee discipline taken post investigation<br>35. Incident Management Review (IMRT) minutes for meetings from 3/1/12 to 7/31/12<br>36. Self-Advocates meeting minutes 2/27, 3/29, 4/24, 5/30, 6/26, and 7/31, 2012<br>37. Under Reporting Record Reviews for each month since 2/12<br>38. UIR Audits for each month since 2/12<br>39. Training transcripts for sample of 25 staff<br>40. Training transcripts for Facility and DFPS Investigators<br>41. Customer Satisfaction Survey (6/30/12)<br>**People Interviewed:**<br>1. Myrna Wolfe, Incident Management Coordinator (IMC)<br>2. Mary Ramos, Quality Management Director<br>3. George Elizondo, OIG Inspector<br>4. Bruce Robertson, APS Program Administrator<br>5. Richard Hawkins, DFPS Investigator Supervisor<br>6. Ten Direct Support Professionals<br>**Meetings Attended:**<br>1. Incident Management Review Team (IMRT) 8/27/12<br>2. Settlement Agreement Performance Improvement Council (SA-PIC) 8/28/12<br>3. RGSC self-advocates meeting 8/29/12 |
| | **Facility Self-Assessment:**<br>The Rio Grande self-assessment reported that the Facility was in substantial compliance with all 22 provisions of this section of the Settlement Agreement (SA). The Monitoring Team determined the Facility was in compliance with 15.<br><br>The Facility's methodology for its self-assessment rating is described in each provision. For example, for Provision D.1, the Facility stated it reviewed policies and conducted a root cause analysis. For Provision D.2 (and others) UIR's and other documents underwent a 100% review to assess compliance. In some instances the self-assessment methodology did not target each specific requirement of a Provision. For example, in validating training requirements for investigators the Facility only evaluated data for its own investigators, not DFPS investigators.<br><br>The Monitoring Team identified several problems that the self-assessment process did not discover. This suggests a need for more thoroughness in the self-assessment process. This was especially evident in the review of Provisions D.3.f, D.3.g, and D.3.h that address the substance of Facility review of investigations.<br><br>The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. Most action plans were described as "Ongoing" or "In Process." It appeared these action steps described activity that occurred since the last review. It was not always possible to link |

| | |
|---|---|
| | deficiencies identified in the self-assessment to a related action plan step. One purpose of the self-assessment is to identify Facility practices that need improvement in order to reach compliance with various requirements of the SA. Flowing from this identification should be one or more action steps that are intended to improve Facility practices. This was not evident in the organization of data in the self-assessment and corresponding action plan.<br><br>The Facility's self-assessment process for Section D often consisted 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 all 22 (100%) to be in substantial compliance. The Monitoring Team determined 15 (68%) to be in compliance. The self-assessment process for Section D is in need of improvement.<br><br>As reported in the last report by the Monitoring Team, the current self-assessment process 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. In a Facility self-assessment process someone from outside the IMC Office should 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.<br><br>Finally, the Facility prepared for the Monitoring Team a "Presentation Book" that is intended to display, for the most part, documentation that can validate work effort that substantiates compliance with specific elements of each Provision. Information and documents in the presentation book are not always organized and presented in a manner that accomplishes this objective. Doing so may help the Facility identify areas of compliance for which documentation is not present or is insufficient.<br><br>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:**<br>The systems for abuse and neglect reporting and the incident management system at RGSC have improved since the last compliance review. Fifteen of the 22 Provisions were determined to be in substantial compliance, four more than reported in the last report by the Monitoring Team.<br><br>The frequency of late reporting of allegations of abuse and neglect remains a concern. Late reporting also |

| | |
|---|---|
| | impacts the Facility's ability to identify and immediately remove alleged perpetrators from contact with Individuals.<br><br>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.<br><br>The content of some investigations, particularly those conducted by the Facility, need improvement. They do not always address obvious considerations in the conduct of a good and thorough investigation.<br><br>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 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.<br><br>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.<br><br>The Facility's policies and procedures include a commitment that abuse and neglect of individuals will not be tolerated, and require that staff report abuse and/or neglect of individuals.<br><br>Through the course of reviewing investigations the Monitoring Team noted that the video surveillance cameras had been helpful in ascertaining the facts associated with many allegations.<br><br>The Facility process for the review of non-serious discovered injuries (to rule out abuse and/or neglect) had improved significantly since the last review.<br><br>The Monitoring Team met with 10 Direct Support Professionals (DSPs) who for the most part demonstrated good knowledge of abuse/neglect and reporting responsibilities.<br><br>Staff training requirements are current. The Facility had an ongoing system for on-the-spot competency testing to ensure staff retains the key requirements of abuse/neglect training.<br><br>Self-advocate meetings are held monthly and are well attended.<br><br>All allegations of physical abuse were appropriately referred to law enforcement. |

| | |
|---|---|
| | The Supervisor of DFPS Investigators, his supervision, and an OIG Investigator all expressed a high level of cooperation between Facility administrative staff and themselves.<br><br>All investigations reviewed by the Monitoring Team began within 24 hours of being reported and were completed within 10 calendar days of the incident.<br><br>The Facility has made office space available to DFPS, and DFPS now has an investigator working out of this office on a regular basis. It was reported that this has facilitated better, and timelier, communication between the Facility and DFPS.<br><br>Presentation of information in UIRs was not always organized in manner that ensures all the requirements of the SA can be readily identified to determine compliance.<br><br>Facility review of investigations did not always ensure that the investigations were thorough and complete and that reports were accurate, complete and coherent.<br><br>The tracking system used by the RGSC to assign responsibility for follow-up disciplinary and programmatic action and monitor the intended actions through completion was well organized.<br><br>Tracking and trending data was complete and regularly analyzed.<br><br>Employee background checks occurred as required by State policy. |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| 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. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported substantial compliance with this provision of the SA. The Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. Reviewed the facility's policies, procedures and practices to determine if the required commitment regarding zero tolerance of abuse and neglect of individuals was included.<br>2. Conducted a Root Cause Analysis. Evaluated all DFPS 10 day reports from 11/2011- 06/2012 to establish a root cause of untimely reporting of Abuse, Neglect and Exploitation.<br><br>From its self-assessment the Facility determined that:<br>1. Review of facility policies, procedures and practices showed that the required | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 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.<br><br>2. Root Cause Analysis revealed that RGSC is 91% compliant with reporting allegations of abuse and neglect within the one hour timeframe. The root cause for reporting untimely is noted to be systemic: one was education of contract staff with the reporting process and another includes how to support Direct Care Staff on meeting the reporting timeframes when they are unable to step away from their 1:1 duty.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance because the required commitment regarding zero tolerance of abuse and neglect of individuals was included in the policy. Root cause conducted evaluated the implementation of policy as evidenced by the 91% compliance rate. The six incidents identified as not reported within the one hour timeframe prompted the initiation of a corrective action plan which was addressed administratively.<br><br><u>Monitoring Team findings:</u><br>The Facility's policies and procedures did:<br>• Include a commitment that abuse and neglect of individuals will not be tolerated,<br>• Require that staff report abuse and/or neglect of individuals.<br><br>The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals.<br><br>The Facility policy stated that all employees who suspect or have knowledge of, or who are involved in an allegation of abuse, neglect, or exploitation, must report allegations immediately (within one hour) to DFPS and to the director or designee.<br><br>In practice, the Facility appeared committed to ensure that abuse and neglect of individuals was not tolerated, and encouraged staff to report abuse and/or neglect, as illustrated by examples provided throughout this section D of the report.<br><br>The criterion for substantial compliance for this provision is the presence and dissemination of appropriate state and facility policies. Implementation of these policies on a day to day basis is monitored throughout the remaining items of section D of this report. | |
| D2 | Commencing within six months of | | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 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 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. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported compliance with this component of this provision of the SA. The Monitoring Team does not concur.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. Quality Management reviewed a randomly selected sample of 2 Unusual Incident investigation files 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.<br><br>2. Completed UIR checklist, for 100% of reported unusual incidents from 3/1/12 – 6/30/12, to include whether or not the incident was reported within the one hour timeframe.<br><br>3. Conducted Abuse and Neglect competency audits form 3/1/12 – 6/30/12, to include ten staff per month. This sample was randomly selected by the Human Rights Officer completing the competency audits. Audit measures staff knowledge on identifying the proper procedure when reporting abuse, neglect, or exploitation.<br><br>4. Conducted a review of Re-Assignment Contracts form 3/1/12 – 6/30/12, to ensure the newly added information on how and who to report retaliation is presented to the re-assigned staff.<br><br>5. Conducted a Root Cause Analysis. Evaluated data spanning from 11/2011- 06/2012 to establish root cause of untimely reporting of Abuse, Neglect and Exploitation.<br><br>From its self-assessment the Facility determined that:<br>1. UIR audit findings were as follows:<br><br>3/14/12 – 100 and 100 for an average of 100%.<br>4/16/12 – 100 and 100 for an average of 100%.<br>5/11/12 – 100 and 100 for an average of 100%. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 6/19/12 – 100 and 100 for an average of 100%.<br>7/20/12 - 95 and 100 for an average of 97.5%.<br><br>2. Nine of ten (90%) unusual incidents reviewed indicated that notifications to DFPS were completed within one hour of suspected abuse, neglect or exploitation. Corrective action was taken for the failure to meet the one hour reporting timeframe. Review of 100% of completed UIRs (from 3/12 through 6/12) noted that 3 of 33 (9%) unusual incidents reported did not meet the one hour reporting timeframe. Corrective action plans were generated and addressed.<br><br>3. Results of the abuse, neglect, or exploitation reporting audit were as follows:<br><br>3/12 - 60% compliance.<br>4/12 - 60% compliance.<br>5/12 - 73% compliance.<br>6/12 - 80% compliance.<br>7/12 – 40% compliance.<br><br>On the spot training was provided to the individuals that did not answer correctly from 3/12 – 7/12. Beginning 6/12, staff who did not obtain a score of 100% were required to attend Abuse, Neglect, and Exploitation (ANE) refresher training.<br><br>4. Results for the 50% of re-assignment contracts reviewed yielded the following results:<br><br>3/12 – 100% (3 of 5 contracts reviewed).<br>4/12 – 100% (3 of 5 contracts reviewed).<br>5/12 – 100% (2 of 4 contracts reviewed).<br>6/12 – 100% (3 of 5 contracts reviewed).<br><br>Zero incidents of retaliation had been reported to the superintendent since the last monitoring visit.<br><br>5. Root Cause Analysis revealed that RGSC is 91% compliant with reporting allegations of abuse and neglect within the one hour timeframe. The root cause for reporting untimely is noted to be systemic: one was education of contract staff with the reporting process and another includes how to support Direct Care Staff on meeting the reporting timeframes when they are unable to step away from their 1:1 duty. Issues identified with reporting untimely have generated Corrective Action Plans, which were addressed and implemented before the finalization of the Root Cause Analysis. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance due to the facility's 91% compliance rate in reporting allegations of abuse, neglect and exploitation within the required one hour timeframe. All three incidents of untimely reporting (since the last monitoring visit) generated corrective action plans and were addressed.<br><br><u>Monitoring Team findings:</u><br>RGSC policy required staff to report abuse, neglect, and exploitation to DFPS within one hour by calling the DFPS 1-800 number. This was consistent with the requirements of the Settlement Agreement.<br><br>From a response to a document request asking for the total number of abuse and neglect allegations and disposition/status for the six month period from 2/1/12 through 7/31/12, the following data were provided by the Facility. These data are provided for information purposes only and reflect some allegations prior to 2/1/12 for which the case report (disposition) was received after 2/1/12:<br>Total Number of Abuse Allegations: 31<br>Confirmed 4<br>Unconfirmed 23<br>Inconclusive 2<br>Administrative Referral 2<br>Disposition Pending 0<br>Other 0<br><br>Total Number of Neglect Allegations: 19<br>Confirmed 3<br>Unconfirmed 9<br>Inconclusive 0<br>Administrative Referral 7<br>Disposition Pending 0<br>Other 0<br><br>Total Number of Exploitation Allegations: none<br><br>RGSC provided a log of serious injuries during the period from 3/1/12 through 8/27/12. From this report the Monitoring Team was able to determine the RGSC had nine serious injuries during this time period. This is an average of 1.5 per month, a decrease from the three serious injuries per month noted in the last review.<br><br>Two samples of investigations were selected for review by the Monitoring Team. These | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | included:<br>• Sample D.1: DFPS Investigations. A sample of six (20% of the 30 investigations between 3/1/12 and 8/27/12) investigations was selected from the list of DFPS cases provided by the Facility. This sample included the following DFPS cases: 41697292, 41850053, 42162903, 42313992, 42335905, and 42346363. These six cases included one case of confirmed abuse, two cases of unconfirmed abuse, one case of confirmed neglect, one case of unconfirmed neglect, and one case of abuse with an inconclusive finding.<br>• Sample D.2: Facility Investigations. A sample of two serious injury investigations (20% of the nine serious injuries between 3/1/12 and 8/27/12) was selected from the facility log of serious injuries. This sample consisted of UIRs: 12-013 and 016.<br><br>Based on a review of the six investigation reports included in Sample D.1, four reported a date and time of the alleged incident. Of these four, two (50%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. Those that did not were DFPS cases 41697292 (reported four hours late) and 42346363 (reported 30 minutes late).<br><br>Serious injuries were reported to the Facility Director according to policy (within one hour). In reviewing the two serious injuries in Sample D.2 both were reported timely.<br><br>The Facility had a standardized reporting format, the Unusual Incident Report (UIR). Based on a review of the eight investigation reports included in Sample D.1 and Sample D.2, eight (100%) contained a copy of the report utilizing the required standardized format.<br><br>Through the course of reviewing investigations the Monitoring Team noted that the video surveillance cameras had been helpful in ascertaining the facts associated with many allegations.<br><br>An additional element of properly reporting allegations of abuse and neglect is the investigation of non-serious discovered injuries. These investigations were 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. The Facility process for the review of non-serious discovered injuries (to rule out abuse and/or neglect) had improved significantly since the last review. The Facility now required that the Executive on Call (EOC) be notified of every discovered injury. The EOC is expected to ask questions about the nature of the injury and to make a preliminary judgment as to whether abuse or neglect is suspected. This notification is to occur within one hour of discovery of the injury. The notification, | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | and information about the injury, are recorded on a weekly report for review by the Incident Management Coordinator (IMC). This process was initiated in May, 2012.<br><br>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.<br><br>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 injury to 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.<br><br>In its last report the Monitoring Team noted none of the sampled discovered injuries were investigated in enough detail to make a reasonable determination to rule out abuse and/or neglect. During this review six injuries were reviewed. Five (83%) were sufficiently investigated. No investigation documentation was provided to the Monitoring Team for an injury to Individual #60 (7/27/12). The other five investigations of discovered injuries contained all required forms and the information on the forms was generally complete without inconsistent information. Additionally, these investigations were reviewed by the Human Rights Officer (who is part of the Quality Assurance Department) who included detailed notes in the investigation file regarding additional follow-up needed to resolve any questions regarding the circumstances of events leading up to the injury. This information was routinely presented to the Incident Management Review Team (IMRT) to ensure executive level oversight. The Facility is to be commended for its improved practices with respect to the investigation of non-serious discovered injuries.<br><br>The Monitoring Team met with 10 Direct Support Professionals (DSPs). Five were from the morning shift and five from the afternoon shift. All were asked to respond to five | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | questions testing their knowledge of fundamental aspects of abuse and neglect, reporting responsibilities, and retaliation. 49 of 50 (98%) possible correct answers were answered correctly. Staff knowledge (at least for these 10 staff) of the fundamental aspects of abuse and neglect, reporting responsibilities, and retaliation was excellent. The Facility had an ongoing system for on-the-spot competency testing to ensure staff retains the key requirements of abuse/neglect training.<br><br>The Facility self-assessment reported its review activity showed that 90% of allegations of abuse and neglect were reported to DFPS timely and 91% of serious incidents (other than abuse and neglect) were reported to the Facility Director/designee timely. The sample used by the Monitoring Team showed that 50% of allegations of abuse and neglect were reported to DFPS timely.<br><br>Because the Facility had not demonstrated consistent reporting of allegations and serious incidents within the required timeframe, this Provision is not in substantial compliance. While incidents of untimely reporting (since the last monitoring visit) generated corrective action plans and were addressed by the Facility more consistent timely reporting of incidents is necessary. Additionally, the Facility self-assessment reported a higher level of compliance with timely reporting (describing a 100% review) than that reported by the Monitoring Team from reviewing its sample of incidents. This suggests the Facility needs to be more thorough in its self-assessment review. | |
| | (b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team does not concur. The frequency of late reporting noted in Provision D.2.a creates situations where alleged perpetrators are not immediately identified and therefore cannot be immediately removed from client contact.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. 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.<br><br>2. Conducted a Root Cause Analysis: evaluated data spanning from 11/11- 6/12 to establish a root cause of untimely reporting of Abuse, Neglect and Exploitation.<br><br>From its self-assessment the Facility determined that:<br>1. For 100% of investigation reports reviewed, named alleged perpetrators were | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | removed from direct contact pending the outcome of an investigation. Alleged Perpetrators were allowed back to their regular work schedules once the investigation was completed by DFPS and corrective action was taken, when applicable. Since the last review (3/12- 6/12), there have been two occasions where the AP was released back to their regular work assignment, after DPFS noted that they had enough evidence to support that the alleged incident did not occur.<br><br>2. Root Cause analysis revealed that RGSC is 91% compliant with reporting allegations of abuse and neglect within the one hour timeframe. The root cause for reporting untimely is noted to be systemic: one was education of contract staff with the reporting process and another includes how to support Direct Care Staff on meeting the reporting timeframes when they are unable to step away from their 1:1 duty.<br><br>Based on the findings of the self-assessment, the Facility determined that 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. Root Cause analysis conducted evaluated the implementation of policy as evidenced by the 91% compliance rate.<br><br>The six incidents identified as not reported within the one hour timeframe prompted the initiation of a corrective action plan which was addressed administratively. Since the last monitoring visit there have been three incidents of untimely reporting, which have generated a Corrective Action Plan and have been addressed.<br><br>Monitoring Team note: the self-assessment does not address actions that may have been initiated to protect individuals other than removing alleged perpetrators. The self-assessment should identify whether other actions to protect individuals, such as retraining staff or reducing environmental hazards, were taken.<br><br><u>Monitoring Team findings:</u><br>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 self-assessment reported that 10% of allegations were discovered to have been reported late. The Monitoring Team, from its Sample D.1, determined a much higher rate of late reporting. Analysis of the six cases in Sample D.1 (DFPS investigations) revealed the following:<br>• In two the date and/or time of the alleged incident was unknown.<br>• In the remaining four allegations the date and time of the alleged incident was known and in two (50%) the allegation was not reported within the one-hour timeframe.<br>Because of late reporting alleged perpetrators are not immediately removed from direct | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | care responsibilities and as a result Individuals are placed at unnecessary risk. The Facility's self-assessment should have identified this problem.<br><br>Review of the six investigations of abuse or neglect in Sample D.1 found there were not any instances in which a staff person who had been removed from direct contact was subsequently returned to normal duties until the investigation had been completed and the investigation review process determined it was appropriate for the staff person to return to his/her normal assignment.<br><br>Based on a review of the eight investigation files in Sample D.1 and D.2, 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.<br><br>This Provision is not in substantial compliance. | |
| | (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. | <u>Facility self-assessment:</u><br>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.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. The IMC reviewed the ABU0100 Course Delinquency List to determine if all RGSC employees had completed the training according to facility policy.<br><br>From its self-assessment the Facility determined that the Delinquency List for ABU0100 dated 7/20/12 revealed that 498 of 503 (99%) of RGSC employees successfully completed this training.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance because 99% of RGSC employees have completed this required training.<br><br><u>Monitoring Team findings:</u><br>RGSC SOP ICF IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation (revision date 7/12) 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 | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | sufficient to demonstrate compliance with the SA.<br><br>A review of the training curricula related to abuse and neglect was carried out for: a) new employee orientation; and b) annual refresher training. The results of this review 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.<br><br>Review of 25 staff records (Sample C.3), 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.<br><br>As an additional check of staff knowledge with respect to abuse/neglect, the Monitoring Team met with 10 Direct Support Professionals (DSPs). Five were from the morning shift and five from the afternoon shift. All were asked to respond to five questions testing their knowledge of fundamental aspects of abuse and neglect, reporting responsibilities, and retaliation. 49 of 50 (98%) possible correct answers were answered correctly. Staff knowledge (at least for these 10 staff) of the fundamental aspects of abuse and neglect, reporting responsibilities, and retaliation was excellent. The Facility had an ongoing system for on-the-spot competency testing to ensure staff retains the key requirements of abuse/neglect training.<br><br>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.<br><br>This Provision is in substantial compliance. | |
| | (d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA and the Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. The IMC reviewed 100% of staff hired between 5/1/12 and 6/15/12 to determine if | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 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 zero tolerance acknowledgements for abuse, neglect and exploitation, and the recognition of reporting obligations have been signed (Form 1020).<br><br>2. The IMC currently completes the Section D monitoring tool quarterly. Two Monitoring Tools were completed between 2/1/12 – 6/31/12. The name of an individual is randomly selected by the RGSC's Quality Management Director, which in turn prompts the facility Incident Management Coordinator to review all corresponding Unusual Incident data utilizing the section D tool. This audit tool measures many aspects of the settlement agreement, in relation to this provision, The IMC extracts data form this tool that relates to staff signing a form annually, noting their obligation to report suspected abuse, neglect, or exploitation, Form 1020. The Incident Management Department reviews all Unusual Incidents to determine whether or not staff has failed to report an incident, by investigating alongside DFPS.<br><br>From its self-assessment the Facility determined that:<br>1. IMC reviewed 100% of staff (18) hired between 5/1/12 and 6/15/12 and noted that 100% of these new employees have signed the required acknowledgement form (Form 1020).<br><br>2. Two Quarterly Section D Monitoring Tools were completed since the last monitoring visit. All staff reviewed have a current Form 1020 completed. All staff has acknowledged their obligation to report abuse, neglect or exploitation.<br><br>Incident Management has noted two incidents of failure to report, since the last monitoring visit. Corrective Action Plans were generated and administrative action was taken.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance because 18 of 18 (100%) of staff hired has signed the acknowledgement form obligating them to call in suspected abuse, neglect, and/ or exploitation. The Incident Management Coordinator continues to complete the Section D monitoring tool to ensure that veteran staff, who have been interviewed by the DFPS and Facility investigators, have a current Form 1020 on file, acknowledging their obligation to report.<br><br><u>Monitoring Team findings:</u><br>Facility policy ICF IID 200-08 (7/12) 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 | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | months prior to the on-site review. All staff hired in the two months had completed the required acknowledgment form.<br><br>Form 1020 was requested for the 25 employees in Sample C.3. Properly signed forms for all 25 staff were provided to the Monitoring Team.<br><br>In response to the pre-visit document request, the Facility identified four instances where allegations of physical abuse were not reported. In each case the employee received a Level One administrative action which places the employee in probationary status for three months. The Facility identified four instances where allegations of physical abuse or neglect were not reported timely. In each case the employee was retrained on abuse/neglect reporting policy.<br><br>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. Failure to report is a serious breach of perhaps the most fundamental requirement of abuse/neglect policy and may merit a more consequential level of administrative action. Nevertheless, the actions taken were consistent with State and Facility policy. 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."<br>. | |
| | (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. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported compliance with this component of this provision of the SA and the Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. Reviewed 100% of Annual Pre-Planning Packets from 3/1/12 – 6/30/12 which were sent to the LAR and Primary Correspondents to ensure that the abuse, neglect and exploitation pamphlets are being sent out to the family and individuals. The pamphlet explains signs and symptoms of abuse and how to report suspicion of abuse.<br><br>2. Human Rights Officer conducted informative sessions during the Self Advocacy meetings, to ensure that individuals are educated on how to identify abuse and neglect, how to report it, and who to ask for assistance in reporting abuse or neglect. Two sessions have been held since the last review.<br><br>From its self-assessment the Facility determined that: | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 1. The review of the 100% of Pre-Planning Packets noted that all individuals and applicable LAR's or primary correspondents were sent the annual letters and provided with educational material to inform them how to identify and report abuse. All packets contained the Abuse and Neglect Pamphlet and included the QDDP case manager call back information, should they have questions or concerns.<br><br>2. Individuals noted on both occasions how to accurately identify those they may request assistance from when reporting abuse, neglect, or exploitation. They identified the following staff: QDDP, nursing staff, DSP Supervisors, Psychology staff, and HRO. Additionally, individuals collectively reported and agreed that they had the right to a safe environment, free from physical, emotional, or verbal abuse. Individuals were able to relay possible symptoms of abuse such as bruises, scratches, and redness.<br><br>The HRO provided physical copies of ANE pamphlets that adhered to the individuals' preferred and dominant language that provided further instruction and education on the ANE reporting process. Additionally, individuals were informed that this information could also be readily located within their residency in the visitors' section, vocational services, and training rooms.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance as preplanning packets are sent out to the LAR/Primary Correspondent. This literature provides an Abuse and Neglect pamphlet which notes the signs and symptoms of abuse and neglect and how to reports this. The individuals are also presented this information by the QDDP before the annual ISP and will again cover this information with them at their annual meeting.<br><br>The Human Rights Officer has also held two Self Advocacy meetings to educate our individuals on how to identify abuse and neglect, how to report it, and who to ask for assistance in reporting abuse or neglect.<br><br><u>Monitoring Team findings:</u><br>Facility policy (ICF IID 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.<br><br>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 families. The IDT is required to meet with each individual prior to their ISP meeting to review this | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 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.<br><br>Self-advocate meetings are held monthly and are well attended with at least one-third of the Individuals living at RGSC in attendance. At the most recent meeting 41 of 70 (59%) Individuals attended. Each meeting included a topic related to abuse and neglect or rights.<br><br>Family members and LARs report frequent visiting. In the last customer satisfaction survey 47% responded to the survey and 82% of the respondents reported they visited at least once every three months. 59% reported they visited at least monthly.<br><br>Eight allegations of abuse or neglect were reported by Individuals, further evidence that they are aware of their rights and exercise them.<br><br>This Provision is in substantial compliance. | |
| | (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. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. The Human Rights Officer (HRO) audited all areas to ensure that at least one poster is up 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. This audit is conducted once per month.<br><br>From its self-assessment the Facility determined that since the last review the walkthrough results are as follows:<br><br>3/16/12- no concerns noted.<br>4/16/12 - no concerns noted.<br>5/14/12 - no concerns noted.<br>6/14/12 - no concerns noted.<br>7/16/12- no concerns noted.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance because "Rights Posters" are displayed in each living unit and day program area. Posters include a brief and easily understood statement of | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | individuals' rights, including information about how to exercise such rights and how to report violations of such rights. Monthly rounds are conducted by the Human Rights Officer to ensure these posters are up and in good condition.<br><br>Monitoring Team findings:<br>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.<br><br>This Provision is in substantial compliance. | |
| | (g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement. | Facility self-assessment:<br>The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. IMC reviews 100% of DFPS cases, from 3/01/12-7/20/12, to determine that appropriate cases were referred to local law enforcement and OIG on a consistent and regular basis.<br><br>From its self-assessment the Facility determined that 100% of all allegations that fit the criteria were referred to law enforcement. The following cases were not reported to OIG: 41571232, 42176412, 42185392, and 42313992. RGSC agrees with DFPS: Three of these cases were neglect cases and one was noted as an emotional/verbal abuse incident. RGSC concurs with DFPS assessment that OIG notification was not warranted on these four cases.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance because 84% of DFPS investigations were reported to law enforcement/ OIG on a consistent and regular basis.<br><br>Monitoring Team findings:<br>In reviewing Sample D.1 (DFPS cases) the Monitoring Team determined one of six did not have law enforcement notification documented in the DFPS case report. This was an allegation of neglect and law enforcement referral was not necessary.<br><br>All allegations of physical abuse were appropriately referred to law enforcement. | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | This Provision is in substantial compliance. | |
| | (h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. Reviewed 100% of all facility investigation reports and DFPS final investigation report, 33 of 33 from 3/1/12 – 7/21/12. 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.<br><br>2. The IMC contacted the Superintendent to cross reference findings and note whether she has received any reports or retaliation.<br><br>From its self-assessment the Facility determined that:<br>1. 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.<br><br>2. The Superintendent reported zero incidents of retaliation received since the last monitoring visit.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance because 100% of Unusual Incidents were reviewed and revealed zero instances where someone felt they had been retaliated against for reporting an allegation in good faith. No one has expressed a fear of being retaliated against, as evident by zero incidents being reported to the Superintendent.<br><br><u>Monitoring Team findings:</u><br>RGSC SOP ICF IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation (7/12) included specific requirements in section IX associated with this component of the SA.<br><br>Based on a review of investigation records (Sample D.1 and Sample D.2), there were no concerns noted related to potential retaliation.<br><br>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 | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | employee who had in good faith had reported an allegation of abuse/neglect/exploitation. There were no instances of reported retaliation.<br><br>During this review the Monitoring Team interviewed two DFPS staff and one OIG investigator. They were unaware of specific retaliation directed towards a reporter of abuse/neglect or other staff interviewed as witnesses.<br><br>Additionally, the Monitoring Team met with 10 Direct Support Professionals (DSPs). Five were from the morning shift and five from the afternoon shift. All reported they had not experienced retaliation, were unaware of any retaliation, and were confident the Facility would address it should it occur.<br><br>This Provision is in substantial compliance. | |
| | (i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported compliance with this component of this provision of the SA. The Monitoring Team does not concur.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. Review of monthly audits, two per month since the last monitoring visit for a total of 10 audits completed by Health Information Management (HIM) to determine if underreporting is noted. This audit consist of a review of all CWS progress notes, nursing assessment and quarterly reviews spanning the previous 90 days. Reviewed crystal injury reports and New Injury Trending Data reports to evaluate trends and determine whether abuse or neglect is suspected.<br><br>From its self-assessment the Facility determined that:<br><br>3/12/12 - No evidence of under reporting noted. Investigator did not suspect abuse or neglect.<br><br>4/17/12 - No evidence of under reporting noted. Investigator did not suspect abuse or neglect.<br><br>5/15/12 - No evidence of under reporting noted. Investigator did not suspect abuse or neglect.<br><br>6/8/12 - No evidence of under reporting noted. Investigator did not suspect abuse or neglect. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 7//12 - No evidence of under reporting noted. Investigator did not suspect abuse or neglect.<br><br>Findings are reported monthly to SA-PIC. Audit results noted 100% compliance. No evidence of underreporting noted.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance due to RGSC's expanded review of audits to include the review of injury data (crystal reports) and New Injury Trending Data reports. The facility investigator evaluated these additional reports and evaluated trends with peer to peer or increases in injuries. All trends identified were addressed by the IDT and required no further investigation or Corrective Action Plans.<br><br><u>Monitoring Team findings</u>:<br>One element of this component of this provision is to identify significant injuries that should have been reported for investigation and validate that they had. To accomplish this the Facility review process should:<br>• Determine whether or not an issue identified by a program auditor is representative of a "significant injury". A significant injury may not necessarily be a serious injury as defined in DADS or Facility policy. For example, issues identified in the audits could involve incidents/injuries such as cuts requiring treatment and injury in the area of the eye (client protection issue). All these could be considered "significant" and may merit closer review in the context of this Provision.<br>• Determine whether or not an issue identified by a program auditor was (or should have been) reported for investigation.<br>• Determine that if the issues identified by a program auditor should have been reported for investigation, and were not, that discovery of this fact resulted in subsequent initiation of an investigation.<br><br>The procedures in place at RGSC that were presented to the Monitoring Team addressed many aspects of these three elements but needs further refinement. For example, the current auditing process does not determine whether an injury was significant.<br><br>In its last report the Monitoring Team noted that an additional purpose of a semi-annual audit of injuries was 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 | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 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 referenced in the SA) could determine that a formal investigation should be initiated. This is especially relevant at the RGSC as the injury rate per 100 individuals at RGSC is twice as high as the average of the other Facilities in the State.<br><br>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.<br><br>This Provision is not in substantial compliance. | |
| 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 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. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA and the Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. Reviewed the training transcripts of the IMC, Facility Investigators, and Campus Administrators to ensure that required training has been completed.<br><br>From its self-assessment the Facility determined that based upon the review of the training transcripts and certificates of the IMC, both (100%) Facility Investigators, and all four (100%) currently employed Campus Coordinators, all had completed Persons with Mental Retardation (MEN0100), Abuse, Neglect & Exploitation (ABU0100), and Unusual Incidents (UNU0100).<br><br>The course Conducting Serious Incident Investigations (INV0100), Root Cause Analysis has also been completed by all. The IMC and both Facility Investigators had | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | completed the Comprehensive Investigator Training (CIT0100) course.<br><br>The IMC and 2 of 2 (100%) facility investigators were certified by Labor Relations Alternatives (LRA) as investigators on 04/26/2012. IMC and the two facility investigators took the competency exam on 04/26/2012 and received their certification.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance as all individuals who conduct investigations at RGSC have completed all of the training requirements.<br><br>Monitoring Team note: the self-assessment was incomplete. It did not include a review of training requirements of DFPS investigators or campus coordinators who are authorized to conduct investigations.<br><br><u>Monitoring Team findings:</u><br>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.<br><br>The Monitoring Team reviewed material used by DFPS in training its investigators. The required class "MH&MR Investigations ILSD" consists of the following modules:<br>1. Introduction and History of DFPS, APS, DADS, and DSHS<br>2. Laws, Rules, & Policies Governing APS MH&MR Investigations<br>3. Dynamics of Abuse, Neglect, and Exploitation<br>4. Psychiatric Terms<br>5. Client Rights<br>6. Prevention and Management of Aggressive Behavior<br>7. Evidence Collection<br>8. Basic Interviewing<br>9. Interviewing Persons with Developmental Disabilities<br>10. MH&MR IMPACT Technical Guide<br>11. Analysis of Evidence<br>12. Effective Writing<br>13. Disposition of Cases<br><br>The required class MH&MR Investigations ILASD includes the following modules: | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 1. Cross-Cultural Interviewing<br>2. Strengthening the Written Report<br>3. Deception and Confrontation of Deception<br>4. Time and Stress Management<br><br>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.<br><br>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.<br><br>Staff designated as principal investigators also are required to complete the LRA training Conducting Serious Investigations (CSI0100) and Root Cause Analysis. The Monitoring Team believes this training, if completed as described, should be adequate for the conduct of investigations at RGSC.<br><br>DFPS reports its investigators are to have completed APS Facility BSD 1 & 2, or MH &MR Investigations ILSD and ILASD depending on their date of hire (APS Facility BSD 1 & 2 are considered equivalent to ILSD and ILASD). While not required most investigators also take a class titled "MH&MR Overview – APS Investigator Role" or similar training classes. Completion of this would demonstrate training in working with people with developmental disabilities.<br><br>DFPS had five investigators assigned to work RGSC cases. The training records for these investigators were reviewed. All five (100%) completed the requirements for investigation training.<br><br>RGSC had three staff designated as principal investigators, which included the Incident Management Coordinator. The Monitoring Team reviewed their training records. All three (100%) had completed all required classes.<br><br>RGSC had an additional five staff (campus coordinators) identified as investigators. The Monitoring Team reviewed their training records. All five (100%) had completed all required classes.<br><br>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. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | This Provision is in substantial compliance. | |
| | (b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation. | Facility self-assessment:<br>The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. IMC conducted 100% review, 33 of 33 from 3/1/12-7/20/12, 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.<br><br>From its self-assessment the Facility determined that all cases reviewed revealed that 100% of facility staff cooperated with DFPS in conducting investigations.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance because review shows that 100% of facility staff cooperated with DFPS in conducting investigations.<br><br>Monitoring Team findings:<br>Review of the investigation files in Sample D.1 and Sample D.2 showed that in all eight (100%) investigations, Facility staff cooperated with DFPS and RGSC investigators.<br><br>In addition, the Monitoring Team interviewed the Supervisor of DFPS Investigators,t he DFPS Administrator who supervised this supervisor, and an OIG Investigator. All 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.<br><br>This Provision is in substantial compliance. | Substantial Compliance |
| | (c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations. | Facility self-assessment:<br>The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA and the Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. IMC conducted a 100% review of DFPS final investigation report, 25 of 25 from 3/1/12-7/20/12, to determine if investigations were coordinated with any | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | investigations completed by law enforcement agencies so as not to interfere with investigations.<br><br>As of 6/1/10, DFPS began notification of allegations of ANE to OIG as deemed appropriate by DFPS and local law enforcement. The Memorandum of Understanding (MOU) dated 6/10 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/IID component of the Rio Grande State Center. The MOU also provides for the coordination of investigations between OIG and local law enforcement.<br><br>Meetings are scheduled with DFPS and OIG as concerns are identified. The first quarterly meeting was held with the DFPS local supervisors and DFPS regional supervisor, Superintendent, Quality Management Director, and Incident Management Coordinator and OIG Supervisor. Concerns discussed where those portrayed by the Settlement Agreement Monitoring Team.<br><br>From its self-assessment the Facility determined that a review of the 100% of DFPS investigations revealed that there is no evidence of interference by one agency or another.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance as no investigations show evidence of interference by either agency.<br><br><u>Monitoring Team findings:</u><br>The Monitoring Team review of investigations did not detect any evidence of interference by one agency or the other.<br><br>This Provision is in substantial compliance. | |
| | (d) Provide for the safeguarding of evidence. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. The IMC reviewed 100% of facility investigation reports and DFPS final investigation reports, 33 of 33 from 3/1/12 – 7/20/12, to determine if evidence had been collected, stored, and secured according to facility policy.<br><br>From its self-assessment the Facility determined that all investigation reports indicated that evidence was being handled according to policy. A review of evidence collected | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | indicates it was all testimonial and documentary, and that no physical evidence had been collected.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance because review showed that evidence was being handled according to policy.<br><br><u>Monitoring Team findings:</u><br>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.<br><br>Additionally, when interviewed by the Monitoring Team neither DFPS or OIG reported any issues with the protection of physical evidence.<br><br>This Provision is in substantial compliance. | |
| | (e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services 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. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported compliance with this component of this provision of the SA. The Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. Reviewed 100% of DFPS and facility 10 day reports and completed the Unusual Incident Investigation Review (UIR) Checklist to assess whether the report was completed within the 10 calendars days as required by policy. The UIR Checklist notes the investigation was initiated and completed within the required timeframe.<br><br>2. Established Quarterly meeting with DFPS, OIG and RGSC staff to discuss concerns and determine how to improve the quality of the facility's investigations.<br><br>3. Incident Management Coordinator reviewed four of four (100%) investigations conducted by DFPS in the month of June to determine if witness statements were collected timely by DFPS.<br><br>4. Incident Management Coordinator reviewed 100% of all DFPS investigations to ensure that DFPS commenced their investigation within 24 hours.<br><br>From its self-assessment the Facility determined that:<br>1. 100% of incidents reviewed (25 of 25) indicated that investigations were processed | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | according to the timeframes required by the SA. 100% were completed within 10 days.<br><br>2. Quarterly meeting, held 05/29/2012, brought about positive results when it was agreed that DFPS would house one of their Investigators on campus to aide in the timeliness of conducting and securing the testimonial evidence.<br><br>3. In one of four (25%) DFPS 10 day reports, interviews commenced on the same day the incident was reported.<br>In two of four (50%) DFPS 10 day reports, interviews commenced within the first 24 hours.<br>In one of four (25%) DFPS 10 day reports, interviews commenced within the first 48 hours.<br><br>4. 100% review of DFPS ten day reports noted that DFPS commenced their investigation by making contact with the facility nurse and Heath Information Management Department to request all documentary information needed, determine that supports for the individuals were taken, and the assessments have been completed.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance due to 100% of investigations being completed within the 10 day timeframe and the improvement noted with the securing of testimonial / witness statements. DFPS commenced investigation by contacting RGSC and requesting/ securing documentary evidence and improvements were noted with the timeliness of securing testimonial evidence.<br><br><u>Monitoring Team findings:</u><br>To measure compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately.<br><br><u>DFPS Investigations</u><br>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 | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 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 six (100%) cases in Sample D.1 documented these type of activities took place within the first 24 hours.<br><br>All six (100%) investigations were completed within 10 calendar days of the incident.<br><br>All eight (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.<br><br>In four of the investigations reviewed, the DFPS report included concerns and recommendations for corrective action that were appropriate to the circumstances of the investigation.<br><br>All six (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed in Provision D.3.f of this report.<br><br>The Facility has made office space available to DFPS and DFPS now has an investigator working out of this office on a regular basis. It was reported that this has facilitated better, and timelier, communication between the Facility and DFPS.<br><br><u>Facility Investigations</u><br>The following summarizes the results of the review of two Facility investigations:<br><br>Documentation contained in the UIR shows that both investigations (100%) commenced within 24 hours or sooner, if necessary, of the incident being reported.<br><br>Documentation contained in the UIR shows that both investigations (100%) were completed within 10 calendar days of the incident, including sign-off by the supervisor.<br><br>Both (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.<br><br>In both of the investigations reviewed, recommendations for corrective action are included and the recommendations appeared adequate to address the findings of the investigation. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | This Provision is in substantial compliance. | |
| | (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. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team does not concur.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. IMC reviewed 100% of facility investigation reports and DFPS final investigation reports, 33 of 33 from 3/1/12 -7/20/12, to determine if the content of the reports show a clear basis for its conclusions. IMC completes the Unusual Incident Investigation Review Checklist to ensure aspects of this provision are included in the Investigation Reports. The checklist includes a checkbox to ensure that the supervisor is reviewing the investigation within the required ten day review timeframe.<br><br>2. IMC and two facility investigators completed the LRA investigator competency exam.<br><br>3. Audit to review 10% of all witnessed injuries was implemented to ensure that they are coded properly, recommendations are appropriate for the injury sustained, discussion is relevant, and implementation for new recommendations are adequately addressed.<br><br>4. Audit to review 100% of discovered injuries was implemented to ensure that they are coded correctly and that the recommendations are appropriate to the injury sustained. IDT discussion (Secondary Investigation Report) is evaluated to ensure that a cohesive and concise discussion is documented.<br><br>From its self-assessment the Facility determined that:<br>1. All investigations reviewed indicated that facility investigation reports and DFPS final investigation reports showed a clear basis for its conclusions. 100% of all DFPS and Facility Investigations included a Checklist, completed by the IMC, noting all investigations included the required information and have been reviewed by the investigators supervisor within the 10 day required timeframe.<br><br>2. All three RGSC staff, IMC and 2 facility investigators completed the exam with an 80 or above and received their certification as an investigator.<br><br>3. 4/12- 100% coded properly.<br>5/12- 36% coded properly.<br>6/12- 60% coded properly. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 7/12- 66% coded properly.<br><br>Percentage rate notes the percentage of injuries reviewed that did not need corrections. All injuries noted to need further IDT actions were sent back to the reviewing case Manager (QDDP) as a Corrective Action Plan.<br><br>4. 6/12 – Review of 5/12's Non-Serious Discovered injury reports noted a 61% compliance rate.<br><br>7/12 – Review of 6/12's non-serious discovered injury reports noted a 58% compliance rate.<br><br>Percentage rate notes the percentage of injuries reviewed that did not need corrections. All injuries noted to need further IDT actions were sent back to the reviewing case Manager (QDDP) as a Corrective Action Plan.<br><br>*All Non-Serious Discovered injuries that were noted as deficient generated a Corrective Action Plan and were returned to the IDT to review with comments noting the concerns.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance due to training the investigators have received. Investigators were instructed on how to document the commencement of their investigations, adding statements in the Unusual Incident Report acknowledging whether abuse and neglect was suspected, and providing statement noting, specifically when abuse and neglect was suspected.<br><br>LRA training and competency exam was provided for the lead investigator. IMC and secondary investigator took the competency exam. All three RGSC staff received their investigator certification.<br><br>Audits were implemented to review both witnessed and discovered injuries, to ensure they are properly coded.<br><br>Incident Management Coordinator continues to review all UIRs completed by the facility investigators to ensure all aspects of this provision are included in the reports.<br><br><u>Monitoring Team findings:</u><br>The contents of the investigation reports utilized a standardized format that set forth explicitly and separately:<br>▪ Each serious incident or allegations of wrongdoing;<br>▪ The name(s) of all witnesses; | |

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

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | The following summarizes the results of the review of Facility investigations:<br><br>In one of two (50%) investigations reviewed the contents of the investigation report were sufficient to provide a clear basis for its conclusion. UIRs 12-013 did not. It contained inconsistent logic that suggests the conclusions reached may not have been as accurate as they could have been. For example, the injury under investigation (fractured ribs) was characterized by medical staff as being one to three weeks old. Video review only occurred for the four days prior to the discovery of the injury, not back in time three weeks. Similarly, staff interviewed were those on duty in the four days prior to discovery. The investigation report states "MD noted that a previous behavioral incident may have led to the injury" but this was only probed superficially, "noted to be engaged in maladaptive behaviors on the days prior to the injury being discovered." Again, the likely time period identified by medical staff was not considered. The injury report associated with this incident reports the probable cause as "use of gait belt." The UIR states "caused his own injury." These conflicting data were not reconciled in the investigation report. This individual had been on 1:1 level of supervision. The investigation report does not make it clear if staff specifically assigned 1:1 responsibility were interviewed back to three weeks prior to the discovery of the injury. Finally, the investigation report does not specify the time period that various documents (communication logs, behavior data, observation notes, etc.) were reviewed. There is no way of knowing if all relevant data was reviewed back in time to what medical staff hypothesized as the time of injury, one to three weeks before discovery. In this investigation the contents of the investigation report were insufficient to provide a clear basis for its conclusion.<br><br>The report utilized a standardized format that set forth explicitly and separately<br>▪ In two (100%), each serious incident or allegations of wrongdoing;<br>▪ In one (50%), the name(s) of all witnesses;<br>▪ In one (50%), the name(s) of all alleged victims and perpetrators;<br>▪ In two (100%), the names of all persons interviewed during the investigation;<br>▪ In none (0%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;<br>▪ In one (50%), all documents reviewed during the investigation;<br>▪ In one (50%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency<br>▪ In two (100%), the investigator's findings; and<br>▪ In two (100%), the investigator's reasons for his/her conclusions.<br><br>In its last report the Monitoring Team noted that presentation of information in the UIR was not always organized in manner that ensures all the details of this component of the | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | SA can be readily identified to determine compliance. To a large extent this appears to be an inherent flaw of the UIR format and design generated by State office. 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 ICF Program. As demonstrated in the case discussion above, it did not appear to the Monitoring Team that this review looks at all available information with a critical eye.<br><br>This Provision is not in substantial compliance. | |
| | (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. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team does not concur.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. IMC reviewed 100% of facility investigation reports and DFPS final investigation reports, 33 of 33 from 3/1/12 -7/20/12, to determine if the content of the reports show a clear basis for its conclusions. IMC completed the Unusual Incident Investigation Review Checklist to ensure aspects of this provision are included in the Investigation Reports. The checklist includes a checkbox to ensure that the supervisor is reviewing the investigation within the required ten day review timeframe.<br><br>2. The Review Authority Team reviews 100% of all DFPS 10 day reports and Facility 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. When the Review Authority notes any concerns with these investigations, a Corrective Action Plan is generated.<br><br>From its self-assessment the Facility determined that:<br>1. All investigations reviewed indicated that facility investigation reports and DFPS final investigation reports showed a clear basis for its conclusions. 100% of all DFPS and Facility Investigations included a Checklist, completed by the IMC, noting all investigations included the required information and have been reviewed by the investigators supervisor within the 10 day required timeframe. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 2. Data evaluated for 3/12-6/12 reflect that Corrective Action Plans (CAPS) were implemented for 22 of 33 (66%) Unusual Incidents.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance as the Incident Management Coordinator continues to review and sign all Facility Investigations and review all of the DFPS 10 day reports to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. A checklist is completed to ensure all required information is included in the Unusual Incident Report.<br><br>The Review Authority Team also reviews all DFPS 10 day reports and Facility Investigations and identifies any concerns with these investigations. The review team will promptly issue a Corrective Action Plan (CAP) when deficiencies or concerns are noted.<br><br><u>Monitoring Team findings:</u><br>RGSC SOPs ICF IID 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.<br><br>A review of Sample D.1 and D.2 validated that reports are reviewed by staff supervising investigations; however; as reported in Provision D.3.f above, this review did not always ensure that the investigations were thorough and complete and that reports were accurate, complete and coherent.<br><br>In addition to those DFPS cases reviewed in Sample D.1 the Monitoring Team reviewed case 41537373 because of its inconclusive finding. The Individual was on 1:1 supervision and was discovered with a black eye. When interviewed by DFPS all staff with 1:1 supervisory responsibility denied having any knowledge as to the cause of the black eye. The language staff used in responding to the investigators questions was remarkably similar. This led to the inconclusive finding. When the Facility reviewed the DFPS case report it reported the Individual "could have self-inflicted the bruised eye while under the bed sheets". This does not seem like a logical hypothesis. If the Individual struck himself with enough force to cause a black eye a diligent 1:1 staff should have heard or | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | observed something. Additionally, the target behaviors described in the UIR associated with this individual did not include self-injurious behavior. This hypothesis was not explored further. This is further evidence that the Facility review of DFPS investigations needs to be more thorough.<br><br>This Provision is not in substantial compliance. | |
| | (h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team does not concur. Issues reported in Provisions D.3.f and D.3.g above demonstrate that the scope of review that results in the review report required in this component is not always sufficient.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. IMC reviewed 100% of facility investigation reports and DFPS final investigation reports, 33 of 33 from 3/1/12 -7/20/12, to determine if the content of the reports show a clear basis for its conclusions. IMC completes the Unusual Incident Investigation Review Checklist to ensure aspects of this provision are included in the Investigation Reports. The checklist includes a checkbox to ensure that the supervisor is reviewing the investigation within the required ten day review timeframe.<br><br>2. IMC and two facility investigators completed the LRA investigator competency exam.<br><br>3. Audit to review 10% of all witnessed injuries was implemented to ensure that they are coded properly.<br><br>4. Audit to review 100% of discovered injuries was implemented to ensure that they are coded correctly and that the recommendations are appropriate to the injury sustained. IDT discussion is evaluated to ensure that a cohesive and concise discussion is documented.<br><br>From its self-assessment the Facility determined that:<br>1. All investigations reviewed indicated that facility investigation reports and DFPS final investigation reports showed a clear basis for its conclusions. 100% of all DFPS and Facility Investigations included a Checklist, completed by the IMC, noting all investigations included the required information and have been reviewed by the investigators supervisor within the 10 day required timeframe.<br><br>2. All three RGSC staff, IMC and 2 facility investigators, completed the exam with an 80 | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | or above and received their certification as a certified investigator.<br><br>3. 4/12- 100% coded properly.<br>5/12- 36% coded properly.<br>6/12- 60% coded properly.<br>7/12- 66% coded properly.<br><br>4. 6/12 – Review of May's Non-Serious Discovered injury reports noted a 61% compliance rate.<br><br>7/12 – Review of June's non-serious discovered injury reports noted a 58% compliance rate.<br><br>*All Non-Serious Discovered injuries that were noted as deficient generated a Corrective Action Plan and were returned to the IDT to review with comments noting the concerns.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance due to training the investigators have received. Investigators were instructed on how to document the commencement of their investigations, adding statements in the Unusual Incident Report acknowledging whether abuse and neglect was suspected, and providing statement noting, specifically when abuse and neglect was suspected.<br><br>LRA training and competency exam was provided for the lead investigator. IMC and secondary investigator took the competency exam. All three RGSC staff received their investigator certification.<br><br>Audits were implemented to review both witnessed and discovered injuries, to ensure they are properly coded. A checklist is currently utilized to ensure that the supervisor is reviewing all 10 day reports, ensuring that the investigations include all required information and if any deficiencies are identified by the review team, they are addressed in a timely manner.<br><br><u>Monitoring Team findings:</u><br>The Facility determined that based on the findings from their self-assessment, this provision was in substantial compliance because reviews indicated that a written report was prepared for each unusual incident. The Facility was correct in reporting a written report was 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. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | RGSC used the IMRT process to review investigation 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 involvement in the review of each case and the written report pursuant to this component included their input. As reported in Provision D.2.g these reviews do not appear to include sufficient substance to investigation conclusions, or to ensure that investigations were thorough and complete. Provision is not in substantial compliance. | |
| | (i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA. The Monitoring Team does not concur. As reported in the last monitoring report, 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.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. Campus Coordinators conducted a random sample of facility investigation reports and DFPS final investigation reports, one per week a total of four per month for the period of 1/1/12 to 4/30/12 to determine if recommendations had been tracked and there was documentation of corresponding outcomes.<br><br>2. Incident Management Coordinator reviewed 25% of the Corrective Action Plans that were issued, related to allegations of abuse or neglect, to determine if they are effective. Review period includes data for 4/12- 6/12.<br><br>3. Conducted debriefing meetings with staff who have been named the alleged perpetrator in two or more DFPS reports within a 12 month period.<br><br>From its self-assessment the Facility determined that:<br><br>1. Results of the UIR Recommendation Audits are as follows:<br><br>1/12 - 100% of recommendations were followed through completion.<br><br>2/12 - 100% of recommendations were followed through completion.<br><br>3/12 -75% of recommendations were followed through completion. Corrective action plans were issued and addressed. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 4/12- 100% of recommendations were followed through completion.<br><br>2. 4/12- Reviewed four Corrective Action Plans to evaluate their effectiveness. In all four instances, there is no further reoccurrence.<br><br>5/12- Reviewed two Corrective Action Plans to evaluate their effectiveness. In both instances, there was no further reoccurrence.<br><br>6/12- Reviewed three Corrective Action Plans to evaluate their effectiveness. In all three instances, there was no further reoccurrence.<br><br>3. Four potential systemic problems and two staff training concerns were identified and corrected since the implementation of these debriefing meetings on 1/1/12.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance as RGSC has a well-developed database to assist with the tracking of all corrective action plans that have been issued. In addition, there has been a process developed to review Corrective Action Plans and determine their effectiveness.<br><br><u>Monitoring Team findings</u>:<br>The Monitoring Team reviewed the tracking system used by the RGSC to assign responsibility for follow-up disciplinary and programmatic action and monitor the intended actions through completion. The database 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. As reported by the Monitoring Team previously, 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 each of the incidents, a corrective action plan (CAP) was established, and tracking was done to identify whether the correction was effective for the specific individual or issue. For example, the follow up was that there were no further incidents, such as "No further occurrences noted involving either PNAs" or "There have been no further incidents involving (individual)." While important to know, these did not address recurrence of the same inappropriate action by other PNAs or occurring to other individuals. The Facility had a process to code CAPs and could identify issues that several CAPs have in common, and then address those to prevent recurrence. Following that, the data gathered to determine effect of the CAPs would measure recurrence of the common issue. For example, staff training was often a recommendation from IMRT reviews. The Monitoring Team was unable to | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 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.<br><br>In additions, the description of the action and measure of effectiveness provided by the Facility in examples did not identify when the action was taken (for example, when a staff was retrained) and how long the time period of compliance was evaluated.<br><br>This Provision is not in substantial compliance. | |
| | (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. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported substantial compliance with this component of this provision of the SA and the Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. Reviewed procedure for the storage of investigation files to ensure that investigators/appropriate personnel have access to every investigation.<br><br>From its self-assessment the Facility determined that review of storage procedure revealed that printed copies were filed in an orderly and up to date manner in the investigation files.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision 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.<br><br>Monitoring Team note; the self-assessment did not address "involving a particular staff member or individual."<br><br><u>Monitoring Team findings:</u><br>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.<br><br>The Monitoring Team did not probe whether DFPS has a similar process by which it can quickly access prior history of alleged perpetrators and alleged victims. If they do not maintain a database they can easily access this information from the Facility IMC. | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | This provision is in substantial compliance. | |
| 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. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported compliance with this provision of the SA and the Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. Reviewed trend reports provided by the data analyst to evaluate and trend unusual incident and investigation results.<br><br>From its self-assessment the Facility determined that results of the database review indicated that tracking, trending and analysis of the data included all aspects specified under this provision. The current trend report continues to track the data over time, allowing the review team to see 12 months of data when conducting their CATW[2] analysis.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision in substantial compliance due to the continued use of the rolling 12 month data now being used to analyze the current data. RGSC continues to provide all the required elements of this provision.<br><br><u>Monitoring Team findings:</u><br>The Monitoring Team review of trend reports validated inclusion of data required under this provision including tracking and trending by: 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.<br><br>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 approximately one year ago by the Facility to encourage those reviewing data reports to engage in critical thinking.<br><br>Each trend report is reviewed monthly at the SA-Program Improvement Council and subjected to the CATW2 process. There was evidence provided to the Monitoring Team that the Facility regularly evaluated this information and was beginning to identify and address perceived systemic issues. Information collected by the Facility should be used to address systemic problems that are barriers to protecting individuals from harm. As the Facility continues to develop its system of quality improvement, these reports will be critical in evaluating progress. Evaluation of the trend information is a necessary | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | component of a process to use these data to protect individuals served and will need to be provided to and reviewed by the Monitoring Team at future compliance visits.<br><br>This Provision is in 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 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. | <u>Facility self-assessment:</u><br>The Rio Grande self-assessment reported substantial compliance with this provision of the SA and the Monitoring Team concurs.<br><br>The Facility reviewed data and determined that 100% of the 515 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 no (0%) employees who had discretionary bars to employment. The Superintendent/designee has exercised a decision making process to determine if they may continue with employment or volunteering.<br><br>Based on the findings of the self-assessment, the Facility determined that 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 or volunteering in an SSLC.<br><br><u>Monitoring Team findings:</u><br>By statute and by policy, all State Supported Living Centers and the Rio Grande State Center were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks.<br><br>In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. Review of a random sample of 25 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director.<br><br>Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | were subject to annual fingerprint checks. Once the fingerprints were entered into the system, the Facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry.<br><br>In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Examination of the self-reporting information documented that no self-reports or "rap-backs" had occurred since the last review.<br><br>This Provision is in substantial compliance. | |

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

1. The Facility needs to continually probe the causes of untimely reporting of abuse and neglect and develop and implement administrative strategies, including but not limited to corrective action plans, to improve timely reporting (Provisions D.1, D.2.a, b, and c).
2. 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 that may identify situations requiring investigation (Provision D.2.i).
3. 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).
4. Establish a QA process that 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:**<br>**Documents Reviewed**<br>1. RGSC Self-Assessment 8/13/12<br>2. RGSC Action Plan 8/9/12<br>3. RGSC Section E Presentation Book<br>4. DADS Policy 3.1 Quality Assurance 1/26/12<br>5. RGSC SOP QM 100.14 DADS Quality Assurance Expectations (7/12)<br>6. RGSC Quality Assurance Plan 7/27/12<br>7. RGSC Improving Organizational Performance Program 7/27/12<br>8. SA-PIC meeting minutes for 2/29, 3/29, 5/24, 7/3, and 7/31, 2012<br>9. RGSC Monitoring Tools and Summary Reports prepared for SA-PIC meetings (undated)<br>10. RGSC Monthly Trend Analysis Report 7/12<br>11. RGSC Quarterly Trend Analysis Report 5/31/12<br>12. RGSC Injury Logs (witnessed and discovered) 3/1/12 to 7/31/12<br>13. Corrective Action Plan (CAP) Reporting from 3/1/12 to 7/31/12<br>14. Sample of completed SA monitoring tools<br>15. Incident Management Review (IMRT) minutes for meetings from 3/1/12 to 7/31/12<br>16. Self-Advocates meeting minutes 2/27, 3/29, 4/24, 5/30, 6/26, and 7/31, 2012<br>17. CAP Audits for May/June, 2012<br>18. Under Reporting Audits for each month since 2/12<br>19. UIR Audits for each month since 2/12<br>**People Interviewed:**<br>1. Mary Ramos, Quality Management Director<br>2. Rosie Sanchez, QE Coordinator<br>3. Alondra Machado, Data Analyst<br>**Meetings Attended/Observations:**<br>1. Incident Management Review Team (IMRT) 8/27/12<br>2. Settlement Agreement Performance Improvement Council (SA-PIC) 8/28/12 |
| | **Facility Self-Assessment:**<br>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 were in substantial compliance.<br><br>The Facility's methodology for its self-assessment rating is described in each provision. It was very detailed and relied primarily on review of data. 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 collection, reporting, and trending was not consistent in all areas of the ICF-ID program.<br><br>For Provision E.3, the Facility self-assessment reported that it maintained an audit system which validated Corrective Action Plans had been properly disseminated. Most CAPs are completed (and closed) long after their target date for completion. The purpose of E.3 is to ensure CAPs are disseminated to responsible |

| | |
|---|---|
| | parties for their implementation. One reason for untimely implementation could be untimely notification. However, the current system did identify the date of CAP notification and the assigned person, and did include follow up reporting at the QA/QI Council.<br><br>Action Plans submitted with the self-assessment addressed areas of noncompliance and articulated actions completed or in process to address those areas. For example, one action step was to "revise trend analysis report to include day of the week, shift, and hour of the day over 12 months." This had a projected completion date of 5/31/12, and a completion status of "completed." The Monitoring Team was able to validate completion when it reviewed the most recent trend reports. |
| | **Summary of Monitor's Assessment:**<br>The Facility had updated its Quality Assurance policy and its Improving Organizational Performance Program document.<br><br>The Facility collects data that is tracked and trended for most provisions of the Settlement Agreement; however, data collection, reporting, and trending were not consistent in all areas of the ICF-ID program.<br><br>The Facility had implemented tracking and trending in subject areas it determined were important after review of other trend data. For example, in reviewing injury data the Facility determined it was important to separately track falls and injuries that resulted from peer-to-peer aggression, and frequently injured individuals. The Facility is to be commended for using basic trend data to identify the need for more finite data collection and tracking.<br><br>The Facility has laid a sound foundation for continued refinement of data tracking required by the SA.<br><br>Since the last review the Facility had developed some CAPs to address systemic issues. This was a new process and still being refined.<br><br>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.<br><br>Since the last review several improvements had been made to CAP reporting. One particularly significant improvement was, at the time of CAP initiation, each CAP was designated as "high urgency" or "low urgency."<br><br>The vast majority of CAPs (including those designated as high urgency) are not completed timely.<br><br>The data system developed by the Facility is extremely flexible and as its use evolves should be very useful for management oversight and performance accountability.<br><br>Still lacking in the Facility QA process are elements intended to address substantive information regarding |

| | |
|---|---|
| | clinical outcomes.<br><br>The Facility may be overly focused on processes associated with various elements of the QA process and not identifying and using readily available data to aggressively address what appear to be significant issues.<br><br>The Monitoring Team did not identify substantive activity occurring that would measure whether any set of activities implemented in multiple CAPs directed at similar subject matter (i.e. Incident Management or infection control) were effective in preventing the recurrence of problems.<br><br>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 implementation of this system.<br><br>As noted in the last report, 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 to encourage those reviewing data reports to engage in critical thinking. The Monitoring Team observed continued implementation of this process.<br><br>As noted in the last report, the Facility had revised much of its trend data to include longitudinal data. This has continued and is especially important at RGSC because the ICF-ID program is so small. |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| 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. | Facility self-assessment:<br>The self-assessment reported noncompliance with this provision of the SA and the Monitoring Team concurs.<br><br>Note: The Facility had continued use of its CATW2 methodology for review of data. 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 helps facilitate the use of data and thoughtful discussion 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.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. Reviewed monthly/quarterly Trend Analysis Reports for Restraint, Injuries, Falls, ANE/Unusual Incidents and Peer to Peer Aggression from 2/12 – 7/12. | Noncompliance |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
2. Reviewed completed the DADS State Office Settlement Agreement Monitoring Tools quarterly from 2/12 – 7/12.<br><br>
3. Reviewed 75 monitoring reports as required by the Quality Assurance (QA) Plan at SA PIC monthly Business Meetings held between 2/12 – 7/12.<br><br>
4. Reviewed findings from the DADS Medical Provider External Audit and the DADS Medical Provider Internal Audit for Round 5.<br><br>
5. Reviewed quarterly ICF Program Departmental Performance Objectives and Measures from 2/12 – 7/12. Areas reviewed include: ICF Program, ICF Nursing, and Health Information Management (HIM).<br><br>
6. Examples of review criteria were:
<table>
<tr><td>ICF IID Services</td><td>90% of ISPs implemented within two weeks.</td></tr>
<tr><td></td><td>PNMT will monitor one individual from each home, selected at random, using the comprehensive monitoring tool.</td></tr>
<tr><td></td><td>Voc. Services will develop and implement one program per quarter which will enhance the lives of the individuals as RGSC.</td></tr>
<tr><td></td><td>All individuals will have an annual psychological assessment at least 10 days prior to staffing.</td></tr>
<tr><td></td><td>RGSC will maintain compliance in 100% of the areas of the Settlement Agreement where compliance has already been met.</td></tr>
<tr><td></td><td>100% compliance with Mock Medical Emergency Drills.</td></tr>
<tr><td></td><td>100% of the individuals at RGSC will receive an accurate risk rating during their annual evaluation.</td></tr>
<tr><td>ICF Nursing Services</td><td>Nursing will assess the benefits of PRN pain medication within one hour.</td></tr>
<tr><td></td><td>Every patient whose rights are restricted will receive an explanation as to why and how they can regain the right restricted.</td></tr>
</table>
</td><td></td></tr>
</table>

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|

| | |
|---|---|
| | Medication Reconciliation will be completed by RN at 90%. |
| | Nursing will complete a Fall Risk Assessment in CWS post fall. |
| | Blood Glucose Monitoring follow-up is completed by the nurse following hypoglycemia protocol will be documented in CWS. |
| | Medication Administration scan rates will be monitored – 90% expectation. |
| | Critical Lab reporting per policy. |
| | 100% completion of the checklists for the oxygen tanks and supplies. |
| | Timely completion and authentication of quarterly and annual nursing assessments. |
| **HIM** | ICF-IID annuals will be transcribed within 24 hours of dictation. |

From its self-assessment the Facility determined that:

1. Five of five (100%) Monthly Trend Analysis Reports (Restraint, Injuries, Falls, ANE/Unusual Incidents, and Peer to Peer Aggression) were presented to Incident Management Review Team (IMRT) for review and analysis using CATW$^2$ from 2/12–7/12.

   Two of two (100%) Quarterly Trend Analysis Reports (Restraint, Injuries, and ANE/Unusual Incidents) for the 2$^{nd}$ and 3$^{rd}$ quarters of FY 2012 were presented to Incident Management Review Team (IMRT) for review and analysis using CATW2 from 2/12–7/12.

   All trend reports were updated in 6/12 to review data on day of the week, shift, and hour of the day over 12 months.

   IMRT Analysis (CATW$^2$) reports and selected opportunities for improvement were completed for five of five Trend Analysis Reports (100%) and provided to the Settlement Agreement Performance Improvement Committee (SA-PIC) for review from 2/12–7/12.

   Examples of selected opportunities for improvement from the injury and restraint trend reports included:

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • The Home Manager will re-train PNAs II/ III and require them to get materials/equipment for activity to be placed in active treatment room during each shift.<br><br>• The Program Specialist will obtain an activities schedule, from Activity Specialist, of possible activities to implement for individuals. These activities should be utilized by the Home Manager when training his staff on active treatment. The Home Manager will discuss their responsibilities on ensuring materials are available in the training rooms.<br><br>• The Program Specialist and QDDP Coordinator will re-implement the process, previously established by the IDT to aid individuals and work towards successful medical and dental appointments. The IDT will continue to review and re-implement supports to ease transitions prior to medical appointments.<br><br>These selected opportunities for improvement were distributed to staff responsible for completion via the Corrective Action Plan process.<br><br>2. DADS State Office Monitoring Tools were completed, as available, and entered into the appropriate databases. Findings reviewed and analyzed by the SA-PIC using CATW[2] for all submitted tools for two of two quarters (100%) from 2/12-7/12. Results were: | |

| Section | FY 2012 – 2nd Quarter Results | FY 2012 – 3rd Quarter Results |
|---|---|---|
| C | 100% | 100% |
| D | 100% | 100% |
| E | 96% | 96% |
| F | 64% | 64% |
| G | Med. Pro. Audit | Med. Pro. Audit |
| H | Med. Pro. Audit | Med. Pro. Audit |
| I | 27% | 0% |
| J | Incomplete | Incomplete |
| K | 92% | 80% |
| L | Med. Pro. Audit | Med. Pro. Audit |
| M | Incomplete | Incomplete |
| N | 0% | 0% |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|

| | | |
|---|---|---|
| O | 89% | 95% |
| P | 76% | 100% |
| Q | No Tool | No Tool |
| R | 70% | 88% |
| S | 10% | 10% |
| T | 100% | 100% |
| U | 17% | 54% |
| V | 74% | 88% |

Seventeen of 20 (85%) of DADS State Office Monitoring Tools were completed as required. Of the tools completed, an average compliance rate of 70% was achieved during both the 2nd and 3rd Quarters of Fiscal Year 2012.

3. Review of SA-PIC meeting agenda/minutes from 2/12 – 7/12 indicated required reporting was at 84%. Twelve of 75 required reports were not completed and reported to SA-PIC as required.

   While this was a decrease in compliance from the 96% average for the 4th Compliance Visit, it should be noted that new reports have been added for review and of these new reports, many are in the beginning stages of reporting.

   These reports include:

   - Employee Satisfaction Survey
   - Friends and Family Satisfaction Survey
   - IDT Peer Review
   - IDT Attendance Monitoring
   - QDRRs/120s/Tapering
   - Engagement Monitoring Form

4. The last External Medical Provider Audit was completed in 6/11. Round 5 Internal Medical Provider Audits were conducted in 7/12. Overall compliance for Essential Elements being addressed by the physician was 86%. Overall compliance for Non-Essential Elements being addressed by the physician was 95%.

   A report of findings from the Medical Provider Audits completed has been pulled from the database and provided to the ICF Services Physician and RGSC Clinical Director for corrective action. Ten CAPs from the Round 5 reviews were initiated at the SA-PIC Business Meeting on 7/31/12. Corrective Action status to be reported monthly.

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 5. The ICF Program Departmental Performance Measures and Objectives for Fiscal Year 2012, 2nd and 3rd Quarters, were reviewed at the SA PIC Business Meeting held on 7/31/12. Results were: | |

| | | | |
|---|---|---|---|
| **ICF IID Services** | 90% of ISPs implemented within two weeks. | Not Met – 77% | Not Met – 75% |
| | PNMT will monitor one individual from each home, selected at random, using the comprehensive monitoring tool. | Met | Met |
| | Voc. Services will develop and implement one program per quarter which will enhance the lives of the individuals as RGSC. | Met | Not Met |
| | All individuals will have an annual psychological assessment at least 10 days prior to staffing. | Not Met – 97% | Not Met – 94% |
| | RGSC will maintain compliance in 100% of the areas of the Settlement Agreement where compliance has already been met. | N/A – no visit | Not Met |
| | 100% compliance with Mock Medical Emergency Drills. | Not Met – 95% | Not Met – 95% |
| | 100% of the individuals at RGSC will receive an accurate risk rating during their annual evaluation. | Met | Met |
| **ICF Nursing** | Nursing will assess the benefits of PRN pain | Met – 90% | Not Met – |

| # | Provision | Assessment of Status | | | | Compliance |
|---|---|---|---|---|---|---|
| | | | **Services** | medication within one hour. | | 88% |
| | | | | Every patient whose rights are restricted will receive an explanation as to why and how they can regain the right restricted. | Met – 100% | Met – 100% |
| | | | | Medication Reconciliation will be completed by RN at 90%. | Met – 100% | Met – 100% |
| | | | | Nursing will complete a Fall Risk Assessment in CWS post fall. | Inc. | Not Met – 81% |
| | | | | Blood Glucose Monitoring follow-up is completed by the nurse following hypoglycemia protocol will be documented in CWS. | Inc. | Met – 100% |
| | | | | Medication Administration scan rates will be monitored – 90% expectation. | Not Met | Not Met |
| | | | | Critical Lab reporting per policy. | Met – 100% | Met – 100% |
| | | | | 100% completion of the checklists for the oxygen tanks and supplies. | Not Met | Not Met – 83% |
| | | | | Timely completion and authentication of quarterly and annual nursing assessments. | Not Met – 85% | Met- 100% |
| | | | **HIM** | ICF-IID annuals will be transcribed within 24 hours of dictation. | Not Met – 82% | Met – 100% |
| | | A report of findings shows seven of 16 (44%) Performance Measures met compliance during the 2nd Quarter (one measure was not applicable during this quarter) and eight of 17 (47%) Performance Measures met compliance during 3rd Quarter. Corrective Action Plans were implemented for those areas falling below the | | | | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | compliance expectation.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision was not in substantial compliance as updated data trending in all areas of the ICF Program had not been in place long enough to evaluate if analysis is consistent in all areas of the program. The Incident Management, Rights, and Health Information Management departments were consistently collecting, analyzing and reporting data according to the expectation of this provision.<br><br><u>Monitoring Team findings</u>:<br>In its last report the Monitoring Team noted that the Facility had revised much of its trend data to include longitudinal data. This has continued and 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 except in the context of longitudinal data. For example, the Injury Trend Report reports the day of the week, shift, and hour of the day for injuries. Reviewing these data over an extended period of time may have implications for staffing, supervision, and activity levels of individuals. For example, if injuries appear to be disproportionally represented on certain days of the week, certain shifts, or in clearly delineated time windows, it's conceivable the Facility may choose to administratively address activity options and staff supervision at particular times of the day in particular locations. These data, when reviewed longitudinally, may give clues as to administrative and programmatic processes that may contribute to outcomes, positively and negatively.<br><br>In addition to the initial tracking and trend reporting required by DADS (i.e. restraint use, injuries, unusual incidents, and abuse/neglect allegations) the Facility collects data which is tracked and trended for most provisions of the Settlement Agreement. This is reported in the Facility self-assessment above. Additionally, some examples of data tracked included:<br>1. Discipline attendance at ISP meetings<br>2. Completion of discipline assessments in a timely manner<br>3. Timeliness of ISP implementation<br>4. Physical Nutritional Management Team (PNMT) interventions and recommendation.<br>5. Vocational services program development<br>6. Administration of emergency medical drills<br>7. Appropriateness of risk ratings, including fall assessments<br>8. Medication administration/errors<br>9. Pain management<br>10. Rights restrictions<br>11. Lab monitoring<br>12. Emergency medical equipment | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | The Facility had also implemented tracking and trending in subject areas it determined were important after review of other trend data. For example, in reviewing injury data the Facility determined it was important to separately track falls (whether or not an injury occurred), injuries that resulted from peer-to-peer aggression, and frequently injured individuals. The Facility is to be commended for using basic trend data to identify the need for more finite data collection and tracking.<br><br>As reported in the Facility self-assessment much of this detailed data collection, report preparation, and analysis is relatively new. The Facility has laid a sound foundation for continued refinement of data tracking required by this Provision of the SA which should lead to compliance. | |
| 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. | <u>Facility self-assessment:</u><br>The self-assessment reported noncompliance with this provision of the SA. The Monitoring Team concurs.<br><br>The Facility reported it had engaged in the following activities to conduct its self-assessment:<br>1. Review of CATW$^2$ analysis from the Trend Reports presented to IMRT between 2/12 and 7/12. CATW$^2$ requires the IMRT to take action on any outliers or areas of concern noted in the data reported.<br><br>2. Review of CAPs initiated for any outliers noted during the review of findings from the DADS State Office Monitoring Tools review quarterly between 2/12 and 7/12.<br><br>3. Review of CAPs initiated for any measures in the QA Plan which do not meet established expectations. This review occurred monthly at the SA-PIC Business meetings between 2/12 and 7/12. CAPs are sent to the Department/Individual responsible and their supervisor and tracked for completion through SA-PIC.<br><br>4. Review of open CAPs, person responsible, team/staff assigned and status occurs at SA-PIC monthly. The number of CAPs opened and closed during the previous month is also reported. Reports were reviewed for the months of 2/12 through 7/12.<br><br>5. Review of CAPs from the DADS Medical Provider External Audit and the DADS Medical Provider Internal Audit for Round 5. This review was completed in 7/12.<br><br>6. Reviewed CAPs from the quarterly ICF Program, ICF Nursing, and HIM Departmental Performance Measures and Objectives reports from 2/12 – 7/12. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 7. Review of completed Systemic CAPs beginning in 8/12 to evaluate if the desired outcome was effective in remedying or reducing the problem identified.<br><br>All CAPs submitted need to have the CAP Reporting Document properly completed prior to entry into the CAPs database. The reporting form includes actions taken to remedy the problem, anticipated outcome, person(s) responsible, and timeframe for completion. In addition, RGSC also expects the CAP to include: Reporting Team/Program Area, Classification, Meeting Date, Level of Urgency, Date of Notification, and Monitoring Frequency. The assigned Quality Advisor will note if the CAP is Systemic or Individualized in nature. Finally, following closure, QM will review the CAP and available data to determine if the CAP was effective in addressing the issue identified.<br><br>A CAP Completion Audit is conducted on 10 closed CAPs monthly to ensure the CAP includes the date the responsible staff for completion were notified of the CAP, the date the CAP is due for completion, the date the CAP was completed, if a copy went to the Supervisor of the staff responsible and if there were appropriate documents for closure.<br><br>From its self-assessment the Facility determined that:<br>1. CAPs initiated from the Trend Reports to IMRT are included in daily IMRT meeting reports and reviewed for initiation and completion status daily. CAPs are closed when all required documentation to address the CAP is submitted to the Settlement Agreement Clerk. Currently, there are 30 CAPs pending completion through IMRT.<br><br>2. Between 2/12 and 7/12, there were no CAPs initiated from the analysis of the Monitoring Tools following the quarterly report at SA-PIC.<br><br>In review of the SA-PIC minutes, 16 items needing action/correction already had a CAP/Action Plan assigned through IMRT, PIC, SA-PIC, or the ICF Provision of Care Committees. CAPs identified issues, action needed, and deficiencies identified by the Committees noted above. The CAP also specifies the methods of correction, responsible party and the date the corrections will be completed, as well as, Reporting Team/Program Area, Classification, Meeting Date, Level of Urgency, Date of Notification, and Monitoring Frequency.<br><br>Review completed in 1/12 for FY 12, 2nd Quarter.<br>Review completed in 5/12 for FY 12, 3rd Quarter.<br>Review scheduled in 8/12 for FY 12, 4th Quarter -<br><br>3. A report of all open CAPs from the QA Plan and initiated within the ICF Program are | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | reviewed for date of initiation and date of completion monthly at SA-PIC. From 3/1/12 to 7/20/12, there were a total of 279 CAPs initiated. As of 7/20/12, 91 CAPs remained open. Of the 91 Open CAPs, the primary areas needing to be addressed were the completion of required staffings and assessments.<br><br>4. A report of all open CAPs is reviewed monthly at the SA-PIC meeting. A report of closed CAPs which shows when initiated, when closed, and team/person responsible is also reported to SA-PIC monthly.<br><br>To ensure proper completion of the CAP, QM staff review that the appropriate documents for closure were submitted with the CAP Reporting Document as part of the CAP Completion Audit. Compliance rates were 100% for each month since the last review.<br><br>5. The last External Medical Provider Audit was completed in 6/11. Round 5 Internal Medical Provider Audits were conducted in 7/12. Overall compliance for Essential Elements being addressed by the physician was 86%. Overall compliance for Non-Essential Elements being addressed by the physician was 95%.<br><br>A report of findings from the Medical Provider Audits completed has been pulled from the database and provided to the ICF Services Physician and RGSC Clinical Director for corrective action. Ten CAPs from the Round 5 reviews were initiated at the SA-PIC Business Meeting on 7/31/12. Corrective Action status to be reported monthly.<br><br>6. The ICF Program, ICF Nursing, and HIM Departmental Performance Measures and Objectives for FY 2012, 2nd and 3rd Quarters were reviewed at the 07/31/2012 SA PIC Business Meeting. The data resulting from this review is presented in Provision E.1.<br><br>7. As this activity is not currently in place, beginning 8/12, Quality Management Staff will be pulling CAP reports by classification category and further review the pattern of CAPs within each classification category to determine if any systemic issues are present and outcome are effective.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because corrective actions taken were not completed in a timely manner. However, CAPs were initiated when required following the analysis of the data, included actions to be taken to address the concern, and were sent to the team/person responsible for action. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Monitoring Team findings:<br>The Facility had updated its Quality Assurance policy and its Improving Organizational Performance Program document. These updates were completed in July, 2012 and included revisions necessary to meet the requirements of the revised DADS QA policy which was issued in January, 2012. These updates also added to each document a description of the Facility's Corrective Action Plan (CAP) process. The Facility's QA policy 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.<br><br>Since the last review the Facility had developed some CAPs to address systemic issues. This was a new process and still being refined. Most were developed in response to incident management reviews. Some of the issues for which systemic CAPs were developed included:<br>• Nail trimming audit because of the prevalence of discovered injuries for which self-scratched appeared to be the probable cause.<br>• Various concerns with the implementation of Individuals Level of Supervision requirements.<br>• Nursing issues related to the completion of Restraint Checklists.<br>• Timeliness of reporting incidents.<br>• Investigation of discovered non-serious injuries by Unit staff.<br><br>Since the last review several improvements had been made to CAP reporting. One particularly significant improvement was, at the time of CAP initiation, each CAP was designated as "high urgency" or "low urgency." High urgency CAPs are to be implemented within 10 days. Low urgency CAPs are to be implemented within 30 days. CAPs are coded in such a way that reports can be prepared and used for managerial oversight and accountability. For example, CAP reports can be prepared that display:<br>1. Open CAPs sorted by high urgency, low urgency, and reporting team responsibility. It is also possible to sort open CAPs by individual staff person assigned responsibility for each CAP.<br>2. Closed CAPs sorted by high urgency, low urgency, and reporting team responsibility. It is also possible to sort closed CAPs by individual staff person assigned responsibility for each CAP.<br>3. High urgency open CAPs whose completion is delinquent by more than 30 days.<br>4. Low urgency open CAPs whose completion is delinquent by more than 30 days.<br>5. CAPs developed to address systemic issues.<br>The data system developed by the Facility is extremely flexible and as its use evolves should be very useful for management oversight and performance accountability. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Still lacking in the Facility QA process are elements intended to address substantive information regarding clinical outcomes. While it was reported some data in this regard is collected and analyzed departmentally (e.g. medical data reviewed by the Medical Director) this information is not as yet folded in to the Facility's formal QA activity. Also, the Facility did not provide any documentation to the Monitoring Team that the QA process formally addressed issues presented in consumer satisfaction surveys and meetings of the self-advocates. 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.<br><br>In its last report the Monitoring Team noted that 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 Monitoring Team did not observe any improvements in this area of QA.<br><br>The RGSC had a Settlement Agreement Program Improvement Council (SA-PIC). This group performed the same functions as the QA/QI Council described in the DADS QA 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 meeting held during the week of the review was not the formal meeting to review trends, etc. From its review of the minutes of other meetings it was apparent to the Monitoring Team that considerable effort goes into preparation of reports for those meetings, and, considerable dialogue occurs at each meeting. These meetings also result in identification of subject matter for which a CAP is subsequently initiated.<br><br>As described above, a process for the development and implementation of Corrective Action Plans was in place.<br><br>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 | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 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.<br><br>Finally, the Monitoring Team is concerned that the Facility may be overly focused on processes associated with various elements of the QA process and not identifying and using readily available data to aggressively address what appear to be significant issues. For example, the Monitoring Team looked at certain key data on trend reports for the five months since the last review (March through July, 2012) and compared those data to the prior five months and found:<br>• Falls had increased 25%.<br>• Injuries had increased 37%.<br>• Serious injuries (while small in number) had doubled.<br>• Injuries related to peer-to-peer aggression had increased 31%.<br>• Confirmed allegation of physical abuse (while small in number) had doubled.<br>The Facility did not appear to identify these issues as related to one another nor identify them as a systemic issue that should be addressed comprehensively. The Facility needs to ensure the data it collects, tracks, trends, and analyzed is used in a substantive manner to address significant trends that effect Individuals health and safety. | |
| E3 | Disseminate corrective action plans to all entities responsible for their implementation. | <u>Facility self-assessment:</u><br>The Facility self-assessment reported compliance with this provision of the SA. The Monitoring Team does not concur.<br><br>The Facility reported it had engaged in the following activities to conduct the self-assessment:<br>1. Reviewed 10 randomly selected closed CAPs monthly from 2/12 to 7/12 to ensure they were sent to the individual(s) responsible for implementation with a copy to their supervisor.<br><br>There were a total of 279 CAPs initiated since the last Monitoring Team Visit. Sixty (22%) of those CAPs were reviewed as part of the CAP Completion Audit to determine compliance with this provision.<br><br>From its self-assessment the Facility determined that analysis of the 60 randomly selected closed CAPs between 2/12 and 7/12 showed an average of 95% of the 60 CAPs reviewed were sent to the department and staff responsible for implementation as well as the appropriate supervisor. Monthly compliance rates were:<br><br>2/12 – 70%<br>3/12 – 100% | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 4/12 – 100%<br>5/12 – 100%<br>6/12 – 100%<br>7/12 – 100%<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is in Substantial Compliance as 95% of CAPs reviewed during the monthly CAP Completion Audit show that the CAP was sent to the individual(s) responsible for implementation as well as the appropriate supervisor. This process is verified by requesting the Notification Document for each CAP reviewed as part of the audit.<br><br><u>Monitoring Team findings</u>:<br>The purpose of this requirement is to ensure that corrective action plans were disseminated to all entities responsible for their implementation soon after each CAP is initiated. The audit system used by the Facility was reviewing a sample of CAPS that had been closed. The majority of CAPs at the Facility are not completed within the timeframe required by those who developed and initiated the CAP. One reason for this could be that dissemination may not have been timely. An audit process to measure compliance with this provision should direct itself to recently initiated CAPs. For example, drawing a sample of 10 CAPs that had been initiated within the prior 30 days, and validating dissemination, would accomplish this.<br><br>Nevertheless, the tracking system implemented by the Facility did identify the date of CAP notification and the assigned person. Review of the CAP Reporting Document and CAP Audit results are completed monthly at the SA-PIC Business Meeting (QA/QI). Evidence of this review was provided to the Monitoring Team. The Corrective Action Plans were disseminated to entities/personnel responsible for implementation. The CAP Tracking Log had been revised to include the date of the CAP's inception, as well as the person ultimately responsible for ensuring the completion of each assigned task. As documented by the meeting minutes and by observation at a QA/QI Council session held during the site visit, content and responsibilities for the completion of the Corrective Action Plans, as assigned, was discussed routinely at the QA/QI Council meetings. Documentation provided to the Monitoring Team included email correspondence delineating responsibility for these tasks. It was evident that the Director of Quality Assurance personally monitored the completion of these assignments. As a result, the Facility was found to be in substantial compliance with this provision. | |
| E4 | Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired | <u>Facility self-assessment:</u><br>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: | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | outcome of remedying or reducing the problems originally identified. | 1. Reviewed 10 randomly selected closed CAPs per month from the CAPs database between 2/12 and 7/12 to ensure full implementation prior to closure, supporting documentation to close the CAP, and whether or not they were implemented in a timely manner.<br><br>There were a total of 279 CAPs initiated since the last Monitoring Team Visit. 60 (22%) of those CAPs were reviewed as part of the CAP Completion Audit to determine compliance with this provision.<br><br>2. Review of completed Systemic CAPs began in 7/12 to evaluate if the CAP was effective in remedying or reducing the problem identified or had the desired outcome.<br><br>From its self-assessment the Facility determined that:<br>1. CAP Completion Audit Findings from 2/12 – 7/12 showed an average of 45% of the 10 CAPs reviewed each month was completed within timeframes established. Compliance rates were:<br><br>2/12 – 40% completed within timeframe provided.<br>3/12 – 40% completed within timeframe provided.<br>4/12 – 50% completed within timeframe provided.<br>5/12 – 60% completed within timeframe provided.<br>6/12 – 30% completed within timeframe provided.<br>7/12 – 50% completed within timeframe provided.<br><br>100% of the 10 CAPs reviewed each month contained the supporting documentation to close the CAP.<br><br>2. Updated the CAP Reporting Document to include CAP Classification, CAP Type (Systemic or Individualized), and Effectiveness.<br><br>The Quality Management Department will use the new reporting document and the CAPs database to separate out only Systemic CAPs to evaluate effectiveness using available data for the concern(s) being reviewed.<br><br>As this activity is not fully in place, there are no specific results to report. However, the evaluation of effectiveness and expected outcome will be data based. Fewer falls, fewer staff needing training, etc. As data is analyzed, CAPs will be modified related to their effectiveness.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | is not in substantial compliance because only 45% of CAPs reviewed were completed within the timeframes provided and the process to review CAPs for effectiveness is not fully implemented.<br><br>Monitoring Team findings:<br>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 implementation of this system.<br><br>The Facility was unable to provide any documentation of any internal process which would determine if a CAP, or set of CAPs addressing a similar subject, was effective in remedying or reducing the problems originally identified.<br><br>Additionally, the fact the vast majority of CAPs (including those designated as high urgency) are not completed timely is evidence that those CAPs, based on timeliness alone, did not meet their desired outcome.<br><br>To achieve compliance, the Facility must ensure CAPs designated as high urgency are completed timely, and most other CAPs are completed within assigned timeframes. Additionally, the Facility needs to establish a mechanism to 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. | Facility self-assessment:<br>The self-assessment reported lack of compliance with this provision of the SA and the Monitoring Team concurs.<br><br>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. Additionally, the Facility reported it did not 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.<br><br>The Facility engaged in the following activities to conduct its self-assessment:<br>1. Reviewed 10 randomly selected CAPs per month between 2/12 and 7/12 to determine if modification to the CAP was initiated or necessary. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | There were a total of 279 CAPs initiated since the last Monitoring Team Visit in 2/12. 60 (22%) of those CAPs were reviewed as part of the CAP Completion Audit to determine compliance with this provision.<br><br>2. Review of completed Systemic CAPs began in 7/12 to evaluate if the CAP was effective in remedying or reducing the problem identified or had the desired outcome.<br><br>From its self-assessment the Facility determined that:<br>1. Of the 60 CAPs reviewed between 2/12 and 7/12, no CAPs were modified. All CAPs implemented addressed the concern noted. Therefore, none of the 60 CAPs reviewed required modification.<br><br>For example, CAP #1119 was initiated to administratively address the failure to report possible Abuse/Neglect/Exploitation. The staff members identified were issued positive performance. This CAP was determined to be effective as data shows there have been no instances of failure to report for these staff members or any other staff member working in the ICF Program since the initiation of this CAP.<br><br>2. Updated CAP Reporting Document to include CAP Classification, CAP Type (Systemic or Individualized), and Effectiveness.<br><br>The Quality Management Department will use the new reporting document and the CAPs database to separate out only Systemic CAPs to evaluate their effectiveness using available data for the concern(s) being reviewed.<br><br>As this activity is not fully in place, there are no specific results to report. However, the evaluation of effectiveness and expected outcome will be data based. Fewer falls, fewer staff needing training, etc. As data is analyzed, CAPs will be modified related to their effectiveness.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because we are unable to determine compliance as no Corrective Action Plans in the sample reviewed required modification and the process to review CAPs for effectiveness is not fully implemented.<br><br><u>Monitoring Team findings:</u><br>As noted above, the Monitoring Team concurs with the Facility self-assessment. The Monitoring Team found no evidence that Corrective Action Plans it reviewed required | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | modification and a suitable process to review CAPs for effectiveness was not fully implemented. | |

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

1. Improve the corrective action plan process, including the development of a methodology to determine their effectiveness. (Provisions E.2, E.3, E.4, and E.5)
2. Implement management control procedures for CAP implementation and hold those responsible for CAP implementation accountable. (Provisions E.2, E.3, E.4, and E.5)
3. As appropriate based on trend data, select and implement additional systemic process improvement initiatives. (Provisions E.2, E.3, E.4, and E.5)
4. Data in all areas of the ICF Program should be consistently collected and trended to facilitate discipline, and interdisciplinary, analyses. (Provision E.1)

| 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:**<br>**Documents Reviewed:**<br>1. RGSC Self-assessment CV 5 dated 8/13/12<br>2. RGSC Action Plans CV 5 dated 8/9/12<br>3. RGSC Entrance Presentation handout<br>4. Presentation Book for Section F<br>5. DADS Draft Policy 018: Most Integrated Setting Practices, undated<br>6. DADS Draft Policy 004.1 Individual Support Plan Process, undated<br>7. DADS Policy 004: Personal Focus Assessment, dated 09/01/11<br>8. DADS SSLC Procedure Instructions for *Preferences and Strengths Inventory* (PSI) undated<br>9. Q Construction: Facilitating for Success training materials<br>10. Personal Support Plan Meeting/Documentation Monitoring Checklist 8/19/11 blank form<br>11. PSP Attendance—All Meeting Types 2/1/12-7/20/12<br>12. PSP Attendance-PSP's only 8/28/12<br>13. Annual Assessments Filed Within 10 Days 2/1/12-7/20/12<br>14. Assessments folder for Individual #48 on share drive<br>15. Individual Support Plans (ISPs) for Individuals #61 and #141<br>16. PBSPs, SFAs, and behavior data graphs were reviewed for six Individuals; Individuals #40, #44, #84, #118, #132, and #134<br>**People Interviewed:**<br>1. Janie Villa, QDDP Coordinator, and Rosie Sanchez, QA<br>**Meeting Attended/Observations:**<br>1. ISP annual planning meetings for Individuals #61 and #141<br>2. Quarterly psychotropic medication review for Individual #3 |
| | **Facility Self-Assessment:**<br>The Facility provided a self-assessment and action plans. For the self-assessment, the Facility reported for each provision the activities engaged in to conduct the self-assessment, results of the self-assessment, and a self-rating with rationale for the rating. RGSC reported it was not in compliance with any of the provisions, or the components within each provision, of this section of the SA. The Monitoring Team concurs.<br><br>The items reviewed had begun to include, for some provisions, data that could be (and may have been) integrated into the Facility's quality assurance system. The Monitoring Team supports the movement toward use of data as appropriate and useful, and would suggest some ways to improve that process of self-assessment. For example, For Provision F1b, attendance data for ISP meetings were reported for one month; these data for June 2012 indicated an attendance rate of 76%. However, one month of data would not be adequate for a self-assessment, as trend information should be reviewed to determine whether progress is being made. For other items, the Facility might establish a measure and process for gathering |

| | |
|---|---|
| | data, including specific sampling procedures. For example, for Provision F1c, the Facility identified from a 10% sample of preparation meetings that "Comprehensive assessments are not routinely completed in response to significant changes in the individual's life." Having an ongoing review, with regular data, might help the Facility not only assess status, but also decide when to take improvement actions.<br><br>For many provisions, a monitoring activity was listed but the activity had not yet been implemented, so no results were available. The Monitoring Team recommends the Facility also develop an overall QA plan involving monitoring tools, QDDP audit tools, active treatment tools and any other applicable tools. The Monitoring Team recommends this be considered a priority towards compliance with this Section.<br><br>Except for two completed actions, all actions in the action plans were either Not Started or In Process. That would not be unexpected, as it is a plan to complete actions to continue moving forward toward compliance. Many of the actions were appropriately not yet started, as they needed to await implementation of the new ISP format and process, for which the initial meetings were held during this compliance visit. It will be crucial for the Facility to begin those process (many of which involve monitoring for accurate implementation and compliance) as soon as possible. In some cases, the action plans for a given provision are sequential in nature, which is a positive finding. For example, for Provision F2a3, the actions begin with training all employees within 30 days of employment (but does not include training current employees, which will also be needed), then moves to training QDDPs on the planned action steps, then to monitoring a sample of ISPs monthly. It will be important for the Facility to continue to develop action steps to ensure the monitoring then leads to improvement actions as needed. |
| | **Summary of Monitor's Assessment:**<br>The new ISP process developed by DADS was implemented during the compliance visit. The Monitoring Team review was based on ISP planning meetings held during the compliance visit and on ISPs developed through this process. With an understanding that this process was newly implemented, the Monitoring Team found the Facility's progress had not been substantial in developing and implementing 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, although some improvements were identified.<br><br>Assessments were not consistently completed timely or updated as the need arose. The new process addresses this need for annual assessments but had not been in place prior to this compliance visit. Although the QDDP was responsible for ensuring the monitoring and revision of treatments, services, and supports, the QDDP did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed. Assessments by some disciplines had improved and were comprehensive, but this was not the case for all clinical disciplines.<br><br>Although IDT member attendance at the two observed annual ISP planning meetings was appropriate, documentation provided by the Facility indicated that attendance did not meet the requirements of this Section. The Facility has tracked attendance but not yet addressed this issue effectively. |

| | |
|---|---|
| | Although it was clear that teams were trying to identify and incorporate individuals' preferences, the new ISPs did not provide evidence that IDTs were skilled at identifying preferences or at identifying supports and services that addressed preferences in a meaningful way.<br><br>Information obtained from record reviews and observations during the current site visit reflected only modest improvement in data utilization and the assessment of treatment effects. Due to the small sample size, as well as a lack of data graphs for some submissions, it was not possible to identify clear trends in data collection and treatment monitoring. The evidence did suggest, however, that the Facility was improving in some areas.<br><br>Training on ISPs had been standardized across the state facilities. Supporting Visions: Personal Support Planning was the standard training curriculum for personal supports planning. DADS had provided training to QDDPs and clinical staff on the new ISP process and on development of skill acquisition plans. The Facility had plans for additional training from DADS. |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| **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: | DADS had developed a new ISP format and process. As agreed to among the parties, Provision F2a will involve only review of ISPs developed through the new process. The first two ISP meetings using the new process were held during the compliance visit. Therefore, these findings are based on review of ISPs for Individuals #61 and #141.<br><br>Training was provided to Facility staff in July 2012. The QDDP Coordinator reported that additional training is planned. | |
| 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 allocated, but one QDDP had recently resigned (leaving three QDDPs to share the caseload), and the Facility was in process of filling this vacancy. In addition, one QDDP position was filled with an acting QDDP.<br><br>According to the Self-Assessment, all four QDDPs had completed facilitation training—the Q Construction: Facilitating for Success training, which included a competency-based component. However, two of those QDDPs no longer serve in that position. It will be important for new QDDPs to receive training as quickly as possible when hired. The two remaining QDDPs had completed the Competency Assessment of Facilitation Skills Training.<br><br>DADS draft policy 004.1 requires the QDDP to assist the individual (and LAR, as appropriate) in leading the team in an interdisciplinary discussion. This was not observed to occur, but the individuals were encouraged to participate. Observation at | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | two annual ISP planning meetings confirmed that the QDDP was the team leader responsible for ensuring team participation.<br><br>The QDDP Coordinator reported that DADS had provided training on the new ISP format and process on 7/24/12. This process was implemented beginning with the ISP planning meetings held during the compliance visit. This process requires changes in procedures, including a meeting held during the third quarterly review that is to include identification of assessments that need to be completed or updated and a review of the Preferences and Strengths Inventory, and identifies the team members required to attend the annual ISP meeting. These had not yet occurred, but the Facility had a plan in place to implement this process prior to each annual ISP planning meeting for ISPs that were being completed during this quarter as well as for regular third-quarter reviews. The assigned QDDP also remained responsible for ensuring the monitoring and revision of treatments, services, and supports. The Monitoring Team found the QDDP did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed as described below under Provisions F2a6 and F2d. The Facility hopes implementation of this process will result in improved completion of assessments, and the Monitoring Team will review this at the next compliance visit. | |
| 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. | <u>Composition and Participation of IDT:</u><br>The Facility tracked the attendance of IDT members at annual ISP meetings. The self-assessment reported these data for June 2012 indicated an attendance rate of 76%. However, in response to the Monitoring Team's pre-visit document request the Facility submitted a document labeled "PSP Attendance-PSP's only 8/28/12" and a document labeled "Monthly Attendance by Discipline 2/1/12 – 7/20/12". These documents were intended to display, by discipline, the frequency of discipline attendance at ISP meetings. The documents contained inconsistent and conflicting data such that it was not useful to the Monitoring Team in assessing compliance with this Provision. For example, one document reported 79 Individuals attended ISP meetings and the other reported 69. Neither report actually displayed the number of ISP meetings from which attendance percentages could be calculated. The number of ISPs attended by particular disciplines appeared to be low. For example, according to the report "PSP Attendance-PSP's only 8/28/12", which reported attendance for 69 ISP meetings, QDDPs attended only 65, DCPs attended only 56, a physician attended only 12, and a psychologist attended only 46. When the Monitoring Team reviewed these documents with the QA Director she agreed it was difficult to interpret the data on the reports.<br><br>The Monitoring Team also checked attendance of habilitation staff as documented in the ISPs for Individuals #29, #47, #51, and #72. No habilitation staff were documented as having attended the ISP annual planning meeting for Individual #72. The PNMT/PNMT | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | RN attended two (50%), an SLP attended three (75%), OT was represented at one (25%), and PT attended one (25%).<br><br>Observation of two ISP planning meetings during the compliance visit indicated that most IDT members who needed to participate were in attendance. At the meeting for Individual #61, eight staff attended, including one Direct Support Professional (DSP). The physician did not attend; given the individual's risk ratings for health conditions and a recent change in health condition, it would have been helpful for the physician to participate. For Individual #141, ten staff attended (per observation by the Monitoring Team, although not all were documented on the ISP or signature sheet), including two DSPs. The physician, psychiatrist, and psychologist did not attend; the individual did not have a positive behavior support plan (PBSP) and was not taking psychotropic medications, and the annual medical assessment and discussion at the meeting did not indicate significant medical concerns. Because the ISP preparation meeting required in the new ISP process had not occurred due to the recency of implementing this process, the Monitoring Team could not determine which team members were required to attend.<br><br>As the new ISP process continues to be implemented, the Facility and Monitoring Team will have more information on which to assess compliance with this provision.<br><br>The Facility tracked attendance at all meeting types. Data provided by the Facility for meetings from 2/1/12-7/20/12, including presence of the individual, LAR, and Local Authority reported 77% attendance at required meetings.<br><br><u>Extent of Individual participation in ISP:</u><br>The individuals attended both ISP meetings. At both, attempts were made to engage the individuals, although not to assist them in leading the meetings. | |
| 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>Extent to which assessments are conducted routinely:</u><br>DADS Draft Policy #004 defined "assessment" as "A formal document that identifies an individual's current level of functioning, preferences, strengths, needs, and recommendations to achieve his or her goals, promote independence, and overcome obstacles to community integration. The assessment is used to identify strengths and needs to support the individual in the development of training, participation, and service objectives listed in the "Action Plans" section of the ISP." In Section III.C, the policy stated: "IDT members prepare for the ISP meeting by completing the recommended and required assessments and placing them on the facility computer shared drive for the IDT to review no later than 10 working days before the annual ISP meeting.<br><br>Assessments for the ISP were still not consistently completed on a timely basis. The expectation, per policy, had been that assessments were to be posted no later than ten | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | days prior to the meeting, such that all team members could review the findings and recommendations in preparation for the meeting. In assessing this Provision the Monitoring Team relied primarily on a list provided by the Facility labeled "Annual Assessments Filed Within 10 Days." The Facility reported these data represented discipline assessments being in (or not) the shared drive 10 days before an Individuals ISP meeting as required by policy. Low levels of compliance were reported. For example, Health Risk Assessment (33%), Functional Skills Assessment (53%), Nutritional Assessment (13%), Speech Assessment (8%), Nursing Assessment (8%), and Personal Focus Assessment (11%).<br><br>The Monitoring Team found that even for the ISPs held during the week of the compliance visit, not all assessments were available. On 8/30/12, the Monitoring Team also reviewed the assessments available on the shared drive for Individual #48, whose annual ISP planning meeting was scheduled for 9/8/12. Only four assessments had been posted—medical, nutritional, functional skills assessment, and draft of the PBSP.<br><br>Furthermore, as reported in Provision M2, only six of 16 (38%) Admission and/or Annual and Quarterly Comprehensive Nursing Assessments were completed according the Facility's ISP schedule. As reported in Provision P1, only 59% (13/22) of the OT/PT assessments were dated as completed ten days prior to the annual ISP meeting.<br><br><u>Extent to which assessments are conducted in response to significant changes:</u><br>There were still many instances in which assessments were not updated when the need arose. For example:<br>• As reported in Provision M1, there had been no improvement in the assessment and documentation when an individual had an acute change in status. Also, annual and Quarterly Comprehensive Nursing Assessments were not revised to reflect significant changes in status or new problems until the next assessments were completed.<br><br><u>Extent to which assessments are of sufficient quality to reliably identify the individual's strengths, preferences and needs:</u><br>There were some improvements noted in some of the assessment processes at RCSC. Examples include:<br>• As reported in Provision J6, psychiatric assessments followed the requirements of Appendix B and were based on current, accurate, and complete clinical and behavioral data.<br>• As reported in Provision L1, physical examinations conducted for the annual medical assessment were more comprehensive than in the past.<br>• As reported in Provision P1, the OT and PT completed annual | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | assessments/updates collaboratively.<br><br>Overall, though, assessments were still not routinely of sufficient quality to reliably identify the individual's strengths, preferences and needs. Examples of assessments that need improvement included:<br>• As reported in Provision M2, there were numerous problematic issues in the Quarterly and Annual Comprehensive Nursing Assessments, such as not consistently documenting and summarizing the effectiveness of medications.<br>• As reported in Provision O2, individuals were not consistently provided with a comprehensive assessment by the Physical and Nutritional Management Team (PNMT) or IDT that focused on nutritional health status, oral care medication administration, and other areas relevant to physical and nutritional management.<br>• As reported in Provision P1, only 54% of sampled OT/PT assessments were identified as comprehensive by the Monitoring Team.<br>• As reported in Provision R2, 67% of 18 sampled assessments were comprehensive and contained all required elements.<br>• As reported in Provision K5, none of 10 sampled Psychological Assessments included a discussion of how assessment finding could be integrated into SAPs.<br>• As reported in Provision K5, none of six reviewed SFAs reflected sufficient detail regarding the assessment process to ensure that assessments were current and contained all necessary components.<br>• For individual #61, conflicting reports were submitted regarding the Individual's ability to look both ways before crossing the street. Some IDT members stated that the Individual had not cooperated with an SAP to teach this skill while other staff reported that the individual was successful in using the skill with supervision. No formal assessment was requested or conducted, but the IDT decided to continue the SAP.<br>• For Individual #141, the ISP reflected considerable discussion about the status of the Individual's vision and whether the prescribed eye glasses were beneficial. Although the Individual had been provided an ophthalmological examination in December of 2011 and had received new glasses in June of 2012, no specific information from the ophthalmological examination was reported. Instead, the ISP reflected that discussion emphasized whether the Individual squinted, bumped into objects, or often fell down. The final determination of the IDT according to the ISP was to allow the Individual time to adjust to the new glasses and to obtain a second pair of glasses. | |
| F1d | Ensure assessment results are used to develop, implement, and revise | <u>Extent to which assessment results are used to develop ISPs:</u><br>Current assessment practices at RGSC, in terms of timeliness, accuracy and thoroughness, | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual. | did not provide assessment results that could adequately be used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual. As described in Provision F1c, assessments required to develop an appropriate ISP meeting were frequently not done in time for IDT members to review each other's assessments prior to the ISP meeting, nor were assessments completed with sufficient thoroughness.<br><br>Observation of the ISP annual planning meeting for Individuals #61 and #141 provided some limited evidence that information from assessments is used to develop an ISP that outlines protections, services, and supports. For example:<br>• For Individual #61, when the IDT discussed the PBSP and the psychiatric evaluation, data were provided.<br>• For Individual #141, the speech pathologist stated the individual has a training objective to identify a dollar; this was selected based on the Speech-Language/Communication Assessment. However, this was raised during a discussion of whether to restrict the individual's right to keep money; the ISP did not state this to be a goal. Furthermore, it is questionable how this would serve as an appropriate communication goal. The assessment identified the individual's communication skills but did not indicate how those could be expanded other than by identifying a dollar. The Speech Pathologist also recommended the PNMP be changed to state that staff should see the Communication Strategies, not the Communication Dictionary, to interact with the individual. The assessment did not identify or specify strategies that would likely be effective for communication. | |
| F1e | Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999). | The 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 whole and the members individually serve as the state's qualified professionals for this purpose. While DADS policy and the SA explicitly state that the decision of the LAR regarding community placement is to be honored, team members at RGSC had been provided clarification and training as to their individual responsibilities to make a recommendation about the most integrated setting both in their individual assessments as well as during the ISP discussion of living options. 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. 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 | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 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. As reported in Provision T1a, less than half the assessments provided by clinicians for the two individuals whose annual ISP planning meetings were held during the compliance visit included a recommendation of the appropriateness of movement to a more integrated setting.<br><br>Developing the ISP in accordance with the ADA and Olmstead decision suggests also that goals be selected that will enhance the likelihood that the individual can live and function in a more integrated environment, or will address an obstacle to movement. ISPs for Individuals #61 and #141 did not include a listing of goals, supports, or services to be provided, so it was not possible to assess whether those goals would involve skills that would enhance living in a more integrated setting. Discussion did include mention of some program goals, including addressing running into the street by Individual #61. Other goals, such as matching coins or identifying a dollar, would not be likely to increase success in living in a more integrated environment.<br><br>The Living Options Discussion did lead to selection of a support for Individual #61 to tour community group homes (the same as a goal the prior year that was not implemented). This was to address the only obstacle to movement identified by the IDT—lack of information about community living. | |
| **F2** | **Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below: | | |
| F2a | Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that: | DADS had developed a new ISP format and process. As agreed to among the parties, Provision F2a will involve only review of ISPs developed through the new process. The first two ISP meetings using the new process were held during the compliance visit. Therefore, these findings are based on review of ISPs for Individuals #61 and #141. | |
| | 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 | 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. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | barrier that is not addressed, identifies the supports that are needed, and encourages community participation; | The Facility had very recently begun to implement the recent revision to the ISP process, which had been incorporated into DADS Draft Policy 004.1: Individual Support Plan Process. This policy at II.F.4 indicated that action plans should be based on the individual's preferences, strengths, and needs. The policy further indicated: "The IDT must have a comprehensive, integrated discussion with input from each team member on how he or she will formally or informally support the prioritized action plans." The revised policy included considerable detail regarding the types of action plans teams should develop (i.e., skill acquisition plans, participation objectives, service objectives, and specific objectives to address individual risk factors); the content of action plans; topics that action plans should cover. It also required teams to "consider every opportunity for community integration," as well as ensure that "Outcomes and objectives are expressed in terms that provide measurable indices of performance…"<br><br>Training had been provided to QDDPs on the use of this updated format. The two ISPs reviewed were the first two developed based on this format and process. Although it was clear that teams were trying to identify and incorporate individuals' preferences and work in a more integrated manner, the resulting ISPs still did not show an integrated plan that set forth the full array of protections, supports, and services individuals required. Additional and extensive training was likely to be needed to prepare teams to think creatively about the needs and preferences of individuals and how to address them on a person-by-person basis.<br><br><u>Extent to which ISP builds on the individual's preferences and strengths and prioritized needs:</u><br>Neither of the reviewed ISPs included information regarding preferences or strengths that was of sufficient validity to be meaningful. Although both provided lists of preferences and strengths, these lists were brief and identified preferences such as "eat at Subway," "look at magazines," "having daily staff interaction," and "likes colors pink and purple" that may have helped plan a daily schedule or the decorations in the environment but did not help identify an optimal living vision or goals for learning.<br>Other concerns included:<br>• For Individual #61, the ISP included a statement that the Individual and the IDT identified various personal preferences and strengths. Observations of the ISP meeting reflected that time was spent during which the IDT sequentially presented a list of activities and strengths. To each activity or strength that was presented, the individual responded with a verbal "yes". In ongoing conversation, however, the Individual continued to repeatedly state "yes", even when no question was asked of her or when the conversation did not include her. It was therefore unclear that the preferences and strengths identified truly reflected what the Individual preferred or considered to be a personal strength. At no time was the Individual's response style commented upon by the IDT, and | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | no IDT member suggested the need for an alternate assessment strategy.<br>• For Individual #141, the ISP included two lists identified as 1) Important Personal Preferences, and 2) Strengths. There was no specific indication in the ISP as to how these lists were developed, the extent to which the individual participated in the development of the lists, or the validity of information included in the lists.<br><br>Neither of the reviewed ISPs included information regarding preferences or strengths that was of sufficient validity to be meaningful in considering appropriateness of a more integrated setting or in establishing goals for learning.<br><br><u>Extent to which ISP builds on the individual's preferences and strengths and prioritized needs:</u><br>IDTs did not consistently address in the ISP each individual's prioritized needs.<br>Little, if any, information about individuals' specific strengths was discussed in ten recent ISP documents. Strengths were not regularly built upon to address other need areas. For example:<br>• For Individual #61, the only action plan that built on an identified strength was a plan to include in her schedule daily social time with her friend next door, which relates to the strength "is social." There was also a goal "Oral Hygiene: SAP will be implemented," which presumably related to the strength "she completes her ADLs with some assistance" but gives no information on what part of oral hygiene would be trained based on what she was already able to do (that is, whether the goal would build from the skill she currently has in completing oral hygiene).<br>• For Individual #141, the only action plans were to obtain a second pair of eyeglasses and to show the individual an exercise bike and see if he had any interest in it. However, there were skill acquisition plans (SAPs) for oral hygiene and using exercise bike, neither of which related to any listed strength (or, for that matter, to any listed preference).<br><br><u>Extent to Which ISP Provides An Explanation For Any Need Or Barrier That Is Not Addressed</u><br>The only barrier discussed was the lack of information Individual #61 had about community living; that was addressed in the ISP.<br><br>In reviewing the ISPS for Individuals #61 and #141, it was difficult to determine when or if the IDT had identified specific needs. This was often due to the lack of clear organization reflected in the ISP documents. Much of the ISP was a description of the discussion held during the meeting, with multiple issues presented within a single | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | paragraph, with a formal conclusion being reached on few if any of these topics. Subjective opinion and anecdotal reports often were presented with little reference to formal assessment information or data. Examples of these issues are presented below.<br>• For Individual #61, in a single paragraph concerning pain management, it was presented that 1) the Individual had conditions likely to result in pain, 2) some pain medications could conflict with her prescribed psychotropic medications, 3) birth control pills might be helpful, 4) some of the medications prescribed for the individual were for seizures while others were for mental illness, 5) the individual had some ability to indicate pain, 6) the individual did not understand the reason for menses, 7) a calendar could be used for tracking menses, but that the individual's menses were often irregular, and 8) the individual had recently been seen by an OB-GYN, but that the issues under discussion had not been addressed in the OB-GYN consult. There was no indication in the narrative that any specific conclusions had been reached by the IDT or that a plan for addressing the identified issues had been formulated.<br>• For Individual #141, the ISP contained an extensive narrative regarding physical fitness. It was noted that the individual enjoyed the Zumba fitness program but that the SAP had been discontinued because Zumba was no longer available. It was clarified that, although the Zumba class had been discontinued, the Zumba DVD could be used at the residence. It was again stated that the individual enjoyed the Zumba activity. The narrative then progressed to discussion of whether the individual enjoyed exercise machines, such as a stationary bike. The IDT decided to how the individual the stationary bike to determine interest. No plan was confirmed in the ISP regarding any actions for Zumba.<br><br>Based upon the information presented in the ISP, it was not clear that the IDT recognized that specific needs had not been thoroughly discussed or adequately addressed. As a result, it was not possible for the IDT to provide explanations for the failure to address specific needs, preferences, or barriers.<br><br><u>Extent to Which ISP Encourages Community Participation</u><br>The only services and supports found in either ISP that encourage community participation were tours of homes and a service to have a family outing for Individual #61. | |
| | 2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the | <u>Extent to Which ISP 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</u><br>The Facility provided the ISPs and the accompanying Integrated Risk Review Forms, Action Plans, and Skill Acquisition Programs (SAPs) for both individuals. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 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; | • Individual #61: In addition to a service to schedule tours to homes, action plans included SAPs and a service to create a daily schedule that will include social time and outing to family home. No strategies were identified to track frequency of tours or responses of the individual to the tours, only an entry in the Clinical Work Station.<br>• Individual #141: The only action plans listed were services—to obtain a second pair of eyeglasses and to show the individual the bike (per discussion at ISP meeting, an exercise bike) to see if the individual shows interest. There were, however, three SAPs attached. One related to the use of the exercise bike, but the other two (both about oral hygiene) were not listed in the action plans.<br><br>The Facility provided a total of seven SAPs for review--five for Individual #61 and two for Individual #141. As noted in F2a1, the discussion described in the ISP document did not reflect a thorough or conclusive discussion of individual needs. As noted in Section S, SAPs generally did not reflect the individual's needs, nor did they contain the requisite essential components of skill acquisition programs such as operational definitions of teaching targets, sufficient repetitions for learning to occur, and or teaching instructions of sufficient detail to ensure staff consistency. In addition, RGSC failed to conduct assessments needed to develop individualized task analyses but instead relied directly on Murdoch Center program task analyses (even though the strengths for Individual #61 indicated some unspecified skill at ADLs that might have affected the starting point of training). As a result, SAPs were not tailored to the unique learning needs, current skills, or physical condition of each person.<br><br><u>Extent to Which ISP Identified Individualized, Observable and /or Measurable Goals/Objectives, the Treatments or Strategies to be Employed, and the Necessary Supports to Overcome Identified Barriers to Living in the Most Integrated Setting</u><br>The only barrier identified in either ISP was for Individual #61. This barrier was Individual Choice. Documentation in the ISP reported that the individual "wants to live at Rio Grande State Center but as mentioned before she has not been exposed to the different options" and further states that the family feels more comfortable with the individual remaining at RGSC. The Action Plan documented in the ISP was for the individual to "be scheduled to tours homes." | |
| | 3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual; | The ISPs, as indicated in F2a1, did not consistently integrate all protections, services, supports, and care/treatment plans. For Individual #141, the ISP provided little information on goals or action plans. There was no indication in the ISP that information and/or services or supports provided by more than one discipline addressed a particular concern or goal. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 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. For example:<br>• As reported Provision I3, risk plans did not document integration between all of the appropriate disciplines.<br>• As reported in Provision O1, 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. This was an area that RGSC was aware of and working towards resolving the issue. Per observation of an ISP for Individual #61, there was much improved discussion and collaboration between team members. Part of the improved discussion focused on review of the PNMP.<br>• Health Maintenance Plans were not provided as an attachment to the ISP, so the Monitoring Team could not determine whether they become part of the ISP materials or how they are integrated into the ISP or include input or participation by relevant clinical disciplines.<br>• Although Individual #61 was identified as requiring a PBSP, no PBSP or behavioral assessment was included in the materials provided by the Facility. A lengthy narrative regarding behavioral issues was included in the ISP document, but it was not evident from that narrative what specific procedures or integrations would be included in the PBSP. | |
| | 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, were blank, or stated "On going."<br><br><u>Methods of Implementation:</u> It was not clear based upon the information included in the SAPs what assessments were used to identify needs or develop teaching strategies. Although SAPs referenced tasks and steps, none of the SAPs indicated that a task analysis had been completed. Furthermore, seven of seven (100%) of the SAPS failed to include operational definitions of the behavior being taught: in each SAP the operational definition was described as the completion of all steps in the SAP.<br><br><u>Time frames for completion:</u> The time frames for completion stipulated in the seven provided SAPs required what would typically be described as excessive. Four of the seven SAPs (57%) required that the individual demonstrate mastery for three | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | consecutive months. The remaining three SAPs (43%) required the individual demonstrate mastery for six consecutive months. This can slow down the progression to greater independence or to learning additional skills without increasing the likelihood the skill will be maintained. | |
| | 5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and | Although both plans, or the attached SAPs, included some practical and functional interventions, neither plan (0%) effectively addressed the individual's full array of needs and supports.<br>• For Individual #141, the Individual had indicated a preferred form of exercise and IDT members had indicated that the means existed to provide the preferred exercise. Rather than addressing the need for physical exercise through continuation of the preferred activity, the IDT opted to present alternate modes of exercise to the individual. No plan was identified to ensure that the Individual obtained the identified exercise.<br>• Although the ISP stated there are plans for Individual #141 to go on pre-placement tours to a designated home and that employment would be considered an essential support because of the individual's preference for working , there was no indication the IDT would review what employment options are available through the designated provider in order to identify skills that could be important for, or work that would be similar to, the available community work, in order to ease transition.<br><br>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. | <u>Extent to which ISP identifies data and/or documentation and the frequency of data collection in order to permit the objective analysis of the individual's progress:</u><br>The Facility provided a total of seven SAPs for review--five for Individual #61 and two for Individual #141. All SAPs provided by the Facility included a description of when data collection was to take place. The ISP did not consistently identify the data and/or documentation and frequency of data collection that would permit the objective analysis of an individual's progress. Although SAPs did reflect data collection instructions, in only two of the seven SAPs (27%) was data collection sufficient to adequately assess progress.<br>• For Individual #141, data collection was to take place five days per week for one SAP and seven days per week for the second SAP. In both cases, this was sufficient to determine progress.<br>• For Individual #61, none of the five SAPs (0%) included instructions to collect data more frequently than once per week. Although skills were to be practiced on other days, limiting data collection to once per week did not provide adequate | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | opportunities to assess the Individual's skill development.<br><br><u>Extent to which ISP identifies the person(s) responsible for the data collection, and the person(s) responsible for the data review:</u><br>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. Even in the action plans in the ISP, the staff responsible for completion of most action plans were not identified. Instead, the staff responsible was listed by job title, such as QDDP or PNA. | |
| F2b | Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP. | As reported in Provision F2a3, this is an area that needs substantial improvement. Although good interdisciplinary discussion was observed during both ISP planning meetings, the ISPs reflect a set of unrelated goals and services. For example:<br>• For Individual #61, an action plan for an outing to family was planned. Although the individual has a SAP for crossing the street, there was no indication that the outing would be used as an opportunity to practice this skill in a community environment.<br>• For Individual #141, the speech pathologist was to take the individual to the gym to look at an exercise bike, and an SAP was developed for using the bike. However, there was no indication that the availability of an exercise bike would be a support included in a Community Living Discharge Plan, nor were there any related plans to support the individual in any other physical fitness, although there had ben discussion during the meeting (and documented in the ISP) about how to provide involvement in Zumba, an exercise the individual reportedly enjoyed but which was no longer being provided. Also, there was no evidence that the individual's eyesight and use of eyeglasses, which was discussed as it related to falls, was considered as part of determining an appropriate exercise program. | Noncompliance |
| F2c | Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it. | The accessibility and staff understanding of these new ISPs could not be assessed, as they were developed and implemented after the compliance visit. Nevertheless, general practices observed at the current visit indicate that ISPs were accessible but that ISPs and the support plans developed from them might not be comprehensible.<br><br>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 | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 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 for action plans 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; although some responsibilities (such as recording vital signs by a nurse on duty) would be obvious, others (such as "Purchase headphones" when assigned to direct service staff) would not be clear, and it would be difficult to ensure accountability for completing the requirement..<br><br>As reported in Provision F2a5, staff were not always familiar with or did not implement interventions. For example:<br>• As reported in Provision O4, mealtime observations (2 lunches and 2 dinners) demonstrated that staff did not implement interventions and recommendations outlined in the PNMPs that were most likely to prevent swallowing difficulties and/or increased risk of aspiration. Staff did not understand rationale of recommendations and interventions as evidenced by not verbalizing reasons for strategies outlined in the PNMP.<br>• In multiple classrooms, little functional engagement was noted. In some circumstances, no materials were available for training or leisure. On other occasions, although materials were available, the materials were not offered to the individuals present until after the classroom observation had progressed for several minutes. | |
| 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 | Active records reviewed included quarterly review, rather than monthly, 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.<br><br>The QDDP Coordinator informed the Monitoring Team that quarterly reviews had recently been replaced by monthly reviews. No monthly reviews were scheduled during the compliance visit, nor was documentation of monthly reviews provided.<br><br>Quarterly psychotropic medication reviews continued to be held. The Monitoring Team attended one such review for Individual #3. Although the focus of the review was on psychiatric treatment, discussion also covered vocational services, medical status, diet, pre-treatment sedation, and "practices" (elsewhere in this report referred to as "dental rehearsals") to address minimizing sedation, visit with family, SAPs, and PNMP. Discussion was interdisciplinary, including several clinicians and a DSP. No data were provided except for weight, so it was unclear what the basis was for reporting impressions of changes in status or progress in programs. This did provide an | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | ISP needs to be modified, and shall modify the ISP, as appropriate. | opportunity for overall review of the individual's status, but it is important for data to be provided as a basis for decisions about progress.<br><br>Other concerns about reviews were identified. For example:<br>• As reported in Provision M2, only 38% of Admission and/or Annual and Quarterly Comprehensive Nursing Assessments were completed according the Facility's ISP schedule. Also,, changes in risk levels were not consistently documented in the nursing assessments, nor did nursing summaries clearly indicate the effectiveness of Health Maintenance Plans or the need for revision.<br><br>Furthermore, as reported in the Self-Assessment, the Facility had not yet implemented a process to monitor whether the responsible IDT member assesses progress and efficacy of interventions monthly. A process to implement monthly reviews of PBSPs was in place, but the PBSPs done in the new format had not been implemented long enough to have had monthly reviews.<br><br>Information obtained from record reviews and observations during the current site visit reflected only modest improvement in data utilization and the assessment of treatment effects. For a sample, the Facility was asked to provide all PBSPs that had been completed in the past six months using the new PBSP format. The Facility provided six PBSPs that met the stated criteria, with only four of the six submitted PBSPs including data graphs.<br><br>Due to the small sample size, as well as a lack of data graphs for some submissions, it was not possible to identify clear trends in data collection and treatment monitoring. The evidence did suggest, however, that the Facility was improving in some areas. There were additional indications, however, that the Facility had deteriorated in other areas.<br><br>Areas of suggested improvement included the following.<br>• For the four out of six PBSPs (67%) where data graphs and progress notes were submitted, treatment targets were individually analyzed for treatment response.<br>• For the four out of six PBSPs (67%) where data graphs and progress notes were submitted, data graphs were sufficient for decision making. Despite the noted sophistication of the data graphs, however, the data were of questionable validity and reliability<br>• For three out of six PBSPs (50%), data graphs indicated that changes in the PBSPs or other interventions had been initiated in response to data trends.<br>• For four out of six PBSPs (67%), the PBSP included specific success and failure criteria.<br><br>Areas of suggested deterioration in performance included the following. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • For none out of six PBSPs (0%) was data collection sufficient to determine progress. For all PBSPs, the specified data collection procedures for undesired behavior allowed data recording to be delayed until the end of the staff person's shift. In addition, there were numerous statements that data collection forms for replacement behaviors were either returned blank or not returned at all. During the previous site visit, data collection was identified as sufficient for 36% of the sample.<br>• Due to the Facility providing data graphs and progress notes for only four of six PBSPs (67%), it was not possible to determine that all PBSPs were reviewed monthly. During the previous site visit, 100% of PBSPs in the sample were reviewed monthly.<br><br>Other indications that monthly review was not completed thoroughly included:<br>• As reported in Provision M5, aspiration trigger sheets were not filled out consistently, and reviews of completed sheets did not consistently result in appropriate actions.<br>• As reported in Provision Q2, dental rehearsal programs were not implemented frequently. There was no indication that review resulted in increasing the number of times these programs were implemented.<br>• As reported in Provision R3, there was quarterly (rather than monthly) documentation of progress on programs for indirect communication supports. Only slightly more than half the communication SAPs had been implemented. For those that were, quarterly documentation did not contain information regarding progress with the stated goal(s). | |
| 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 | Training on ISPs had been standardized across the state facilities. 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.<br><br>According to the Self-Assessment, all four QDDPs had completed facilitation training—the Q Construction: Facilitating for Success training, which included a competency-based component. However, two of those QDDPs no longer serve in that position. It will be important for new QDDPs to receive training as quickly as possible when hired. The two remaining QDDPs had completed the Competency Assessment of Facilitation Skills Training.<br><br>The QDDP Coordinator reported that DADS provided training to staff of the Facility on the new ISP format and process on 7/24/12 and 7/25/12. The first day of the training was on ISPs; the second day was on SAPs. Training was provided to QDDPs and to many | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 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. | clinicians, including habilitation staff and Nurse Case Managers,. She reported that an additional training session is planned. Because the Facility is in process of filling two QDDP positions, these individuals will be sent for training as soon as possible after they begin work.<br><br>The QDDP Coordinator reported she monitors Q facilitation skills annually, but no other information was provided on plans for refresher training to QDDPs and other staff responsible for development of ISPs.<br><br><u>Competency based Training on Implementation of Plans</u><br>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. There were examples of competency-based training provided to individuals who would need to implement plans.<br>• DSPs 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:<br>o Dining<br>o Adaptive feeding equipment<br>o Adaptive equipment (gait belt, lift vest, orthotics, bathing, and range of motion)<br>o Dysphagia<br>• 91% of HMPs contained documentation that the direct support professionals were trained and had special instruction sheets developed for the Me Books.<br><br>However, there are numerous examples in this report indicating a lack of training.<br>• As reported in Provision O5, for zero of five (0%) for whom there was a downgrade in food texture, there was evidence of staff training regarding the change in care which in this case focused on the texture downgrade. 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.<br>• As reported in Provision R3, staff interviews indicated that DSPs were not consistently able to describe whether an individual had a communication program, the goal of the program, where data was reported, or the schedule for implementation. Only one of six DSPs interviewed stated that they had received individual-specific training for the program and/or communication device.<br>• Documentation provided by RGSC reflected no competency-based training for staff had been implemented in relation to PBSPs. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | | |
| 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>Extent to which ISPs are revised annually and as needed and are put into effect within 30 days of preparation:</u><br>In assessing this Provision the Monitoring Team relied primarily on a list provided by the Facility that included each Individual in residence, the date of their most recent ISP meeting, the date of the previous ISP meeting, and the date the most recent ISP was put into effect. From this list the Monitoring Team was able to determine:<br>• All 67 ISP meetings included in the reported data occurred within 365 days of the previous ISP meeting.<br>• Forty-six of 67 (54%) Individuals did not have their ISP put into effect within 30 days of the ISP meeting. Several were extremely delinquent. For example, the list provided by the Facility showed that Individual #23's ISP meeting was on 4/3/12 and was not put into effect until 7/23/12. Individual #66's ISP meeting was on 4/12/12 and was not put into effect until 8/9/12. Individual #133's ISP meeting was on 5/3/12/12 and was not put into effect until 8/6/12.<br><br>From R2 for a sample of 3 newly admitted individuals:<br>• Three of three individuals (100%) received a communication screening or assessment within 30 days of admission or readmission.<br>• Three of three individuals identified with therapy needs through a screening (100%) received a comprehensive communication assessment within 30 days of identification. | Noncompliance |
| 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 Self-Assessment reported that no monitoring data is available.<br><br>However, the Facility provided data on attendance at ISP meetings, and on assessments filed within 10 days; these are both important sets of data. There was not yet indication that analysis was done of these data leading to corrective or improvement actions. As reported in this Section, not all needed staff attended ISP annual planning meetings (although there was not yet a way to be certain of all staff needed), and assessments were not consistently posted timely.<br><br>Furthermore, as noted in several section of the report, ISPs were not fully, consistently, or accurately implemented.<br><br>The Facility must implement quality assurance processes to identify and remediate problems with implementation of the newly-established ISP process and format, with timeliness and comprehensiveness of assessments, and with implementation of supports and services identified in ISPs. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | | |

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

1. The Monitoring Team recommends the Facility also develop an overall QA plan involving monitoring tools, QDDP audit tools, active treatment tools and any other applicable tools. (Self-Assessment)
2. The Facility must implement quality assurance processes to identify and remediate problems with implementation of the newly-established ISP process and format, with timeliness and comprehensiveness of assessments, and with implementation of supports and services identified in ISPs. (Provisions F1c and F2g)
3. Develop and implement a process to review and improve quality and comprehensiveness of assessments. (Provision F1c)
4. Consider establishing guidelines for more organized documentation of discussion and decisions in the ISP. This should be done in collaboration with DADS trainers to ensure documentation is consistent with the new ISP process. DADS and the Facility might consider whether it would be useful to have the DADS trainer review the first few ISPs and provide feedback on documentation. (Provision F2a1)
5. SAPs must be tailored to the unique learning needs, current skills, or physical condition of each person, and should be based on task analyses that are individualized based on those unique issues. Also, time frames for completion should be reviewed to ensure they are not excessive. (Provisions F2a3 and F2a4)
6. Establish training, monitoring, feedback, and other actions to ensure staff comprehend and are able to implement both formal SAPs and active engagement activities as planned. (Provision F2c)
7. Implement procedures to ensure staff responsible for implementation of interventions and supports receive competency-based training. (Provision F2e)

| 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:**<br>**Documents Reviewed:**<br>1. RGSC Self-assessment CV 5 dated 8/13/12<br>2. RGSC Action Plans CV 5 dated 8/9/12<br>3. RGSC Entrance Presentation handout<br>4. DADS draft policy #005: Minimum and Integrated Clinical Services 1/12/10<br>5. RGSC SOP ICF-IID 400-14 Medical Care July 2012<br>6. RGSC ICF Referral/Consultation Report form<br>7. PSP Attendance-PSP's only 8/28/12 document<br>8. Individual Support Plans (ISPs) for Individuals #61 and #141<br>9. ISPs, assessments, CLDPs, and other documents reviewed by members of the Monitoring Team, as identified in other sections of this report<br>10. Integration of Psychology and Psychiatry document<br>11. Minutes of Team Integration Meetings of 7/16/12, 7/18/12, 7/19/12, 7/20/12, 8/28/12, and 8/29/12<br>12. Agenda of Integration of Clinical Services Meeting of 8/29/12 with Attachment A: Adverse Drug Reaction Process<br>13. Consultation reports: Medical for Individuals #1, #8, #46, #47, #72, #81, and #118, and MBSS for Individuals #26, #60, #79, and #98<br>14. RGSC Referral/Consultation Form<br>15. Sample Client Work Station (CWS) Physician Progress Note noting follow up of consult<br>**People Interviewed:**<br>1. Group interview of Lorraine Hinrichs (ICF-DD Director), David Moron, M.D. (Clinical Director), and Juan Gonzalez (Program Improvement Specialist)<br>**Meeting Attended/Observations:**<br>1. Team Integration Meeting 8/29/12 |
| | **Facility Self-Assessment:**<br>The Facility provided a self-assessment and action plans. For the self-assessment, the Facility reported for each provision the activities engaged in to conduct the self-assessment, results of the self-assessment, and a self-rating with rationale for the rating.<br><br>The Facility reported it was not in compliance with either provision of this Section. The Monitoring Team concurs.<br><br>The self-assessment provided data for several assessment items, such as timeliness of completion of assessments. Interestingly, data were provided from both the Health Information Management (HIM) database and the data on percent of assessments completed 10 days prior to staffing; these provided extremely different percentages (over 90% for HIM, 21% for assessments 10 days prior to staffing). |

| | |
|---|---|
| | However, the rationale for the self-rating did not mention either of these sets of data but focused on other issues such as attendance at IDT meetings (also an appropriate measure for this self-assessment). IDT attendance (presumably at ISP planning meetings) was reported as 76%. These are good measures and can be part of routine quality assurance measurement but must be refined and clarified so the most appropriate measures (for example, of completion of assessments) are selected and tracked. The Facility needs to review the requirements of the provision and the findings from compliance reports, and then identify specific data that would help the Facility identify status and track progress toward compliance.<br><br>For Provision G2, the Facility focused only on medical provider audits. Although most consultations are medical, there may be other consultations. A more direct measure would be some sampling of consultation reports to determine whether review, documentation, and referral to IDT were done consistently and correctly.<br><br>All action plans but one were described as "In Process" with one that had not been started. These were actually descriptions of ongoing processes rather than identification of particular outcomes needed for compliance and a sequential plan of action to reach each outcome, although it was clear in discussions with Facility staff that some actions were planned. The Facility should determine and describe organized plans for specific actions to progress toward compliance. |
| | **Summary of Monitor's Assessment:**<br>The Facility had continued to progress toward providing clinical services in an integrated manner. Policies and processes to improve integrated planning both for individuals and for systemic improvements continued to evolve. Nevertheless, integrating planning and services across disciplines remained a challenge.<br><br>Through observations, interviews, and reviews of documentation, the Monitoring Team identified examples of both integration of clinical services and opportunities for greater integration. Attendance by various clinical disciplines at the annual ISP planning meetings needed to improve. Important medical conditions were identified by physical examination, but were not included as medical diagnoses, and there was no action plan developed for these conditions. Because the IDT was not made aware of any of these conditions, the Monitoring Team has concern that medical issues are not well integrated into the IDT process. Assessments for the ISP were still not consistently completed on a timely basis.<br><br>There were also examples of improved integrated clinical services. The infection Control Preventionist maintained Antibiotic Susceptibility of Common Organisms Reports, attended the Pharmacy and Therapeutic Committee Meetings and shared the information with the Pharmacist and physicians. The Medication Administration Workgroup meetings were integrated and involved participation by several disciplines, as were the Pharmacy and Therapeutics Committee meetings. One positive finding was the continued evolution of the Morning Medical meeting, which was now called the Team Integration Meeting; as this meeting continues to evolve, it should provide a good opportunity to expand further integrated planning on both individual and systemic issues. |

| | |
|---|---|
| | The Facility used a consultation form to document review by Facility physicians of non-Facility consultant reports. For each, an Integrated Progress Note was to be written. There was no similar process for other (that is, nonmedical) clinical consultations. Consultation forms generally provided documentation of agreement or non-agreement with recommendations. IPNs were not consistently found, and there was no evidence on these forms or in IPNs of referral to the IDT, although a process reportedly existed that included IDT review of consultations.<br><br>Furthermore, all dental services were provided by community dentists; there was no evidence of review of dental consultant recommendations by a Facility clinician. |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| G1 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need. | The Facility had continued to progress toward providing clinical services in an integrated manner Policies and processes to improve integrated planning both for individuals and for systemic improvements continued to evolve.. Nevertheless, integrating planning and services across disciplines remained a challenge, and this provision was not yet in compliance.<br><br>RGSC SOP ICF-MR 400-14 contained expectations for integration of medical care into the ISP. The QDDP 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 participant. The recent revision to the policy also requires the PCP to document in the medical record the rationale associated with decisions whether to implement the recommendations and to provide a copy of the consult form to the QDDP. The IDT is expected to review the recommendations and action plans as needed.<br><br>A draft DADS statewide policy had also been available for over a year. It addressed both integrated clinical services (section G) and minimum common elements of clinical services (section H). The aspects of the policy that addressed section G were minimal and will not likely be helpful to the Facility because the policy merely repeated the wording of the Settlement Agreement without providing any direction to the Facility, such as 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.<br><br>Through observations, interviews, and reviews of documentation, the Monitoring Team identified examples of both integration of clinical services and opportunities for greater integration. A few examples follow:<br>• Attendance by various clinical disciplines at the annual ISP planning meetings needed to improve.<br>o According to the report "PSP Attendance-PSP's only 8/28/12", which | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | reported attendance for 69 ISP meetings, QDDPs attended only 65, a physician attended only 12, and a psychologist attended only 46.<br>o Observation of two ISP planning meetings during the compliance visit indicated that most IDT members who needed to participate were in attendance. At the meeting for Individual #61, eight staff attended, including one Direct Support Professional (DSP). The physician did not attend; given the individual's risk ratings for health conditions and a recent change in health condition, it would have been helpful for the physician to participate. For Individual #141, ten staff attended (per observation by the Monitoring Team, although not all were documented on the ISP or signature sheet), including two DSPs. The physician, psychiatrist, and psychologist did not attend; the individual did not have a positive behavior support plan (PBSP) and was not taking psychotropic medications, and the annual medical assessment and discussion at the meeting did not indicate significant medical concerns.<br>• As reported in Provision L1, for Individual #79, important medical conditions were identified by physical examination, but were not included as medical diagnoses, and there was no action plan developed for these conditions. Because the IDT was not made aware of any of these conditions, the Monitoring Team has concern that medical issues are not well integrated into the IDT process.<br>• As reported in Provision M1, the infection Control Preventionist maintained Antibiotic Susceptibility of Common Organisms Reports, attended the Pharmacy and Therapeutic Committee Meetings and shared the information with the Pharmacist and physicians.<br>• Zero of 46 (0%) HMPs were developed in collaboration with other relevant disciplines, with the exception for occasionally referring to other disciplines, e.g., Physical Nutritional Management Plans (PNMPs) and/or (Personal Behavior Support Plans (PBSPs).<br>• 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. This was an area that RGSC was aware of and working towards resolving the issue. Per observation of an ISP for Individual #61, there was much improved discussion and collaboration between team members. Part of the improved discussion focused on review of the PNMP.<br>• Individual #47 was provided with a comprehensive interdisciplinary assessment by the Physical and Nutritional Management Team (PNMT) following a diagnosis of pneumonia. Individuals #26, #60, and #79, who were diagnosed with pneumonia, were not provided with interdisciplinary assessments or discussion by the IDT or PNMT.<br>• The Medication Administration Workgroup meetings were integrated and | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | involved participation by several disciplines, as were the Pharmacy and Therapeutics Committee meetings.<br>• The Speech Language Pathologist provided basic training on dysphagia and communication to the incumbent nursing staff.<br>• There were no individuals reviewed for whom the nursing staff demonstrated collaboration/integrated clinical services with other disciplines for direct care issues.<br>• A new comprehensive assessment format that included assessment by OT and PT was in use at the Facility.<br>• The document Integration of Psychology and Psychiatry provided a good plan and process for integrated planning. However, as documented in Provisions J8 and J9, and with the lack of behavioral indices of mental illness as reported in Provision K5, it appeared that this process had not yet resulted in the level of improvement needed.<br><br>One positive finding was the continued evolution of the Morning Medical meeting, which was now called the Team Integration Meeting. This meeting occurred Monday through Friday morning. Physicians, a psychiatrist, the QDDPs, a psychology assistant, the PNMT nurse, and nurse case managers were among the participants. There was review of individuals who were hospitalized and or discharged to the Facility the day before. Issues from overnight call coverage were reported. Individuals who had any health-related problems or acute change in status were discussed. Some items were simply reports so the QDDPs would have information to share with their teams and to identify what follow-up would be needed. Other discussions were more involved; discussion was interdisciplinary. At the meeting of 8/29/12, Dr. Partin provided information about fecal smearing and the health issues it could indicate; he pointed out the need for incidents to be reported, and he offered to provide staff an inservice training.<br><br>The Facility also provided minutes of five additional Team Integration Meetings. As this meeting continues to evolve, it should provide a good opportunity to expand further integrated planning on both individual and systemic issues.<br><br>At the time of the last compliance visit, an organization change had been put into place in which a nurse case manager and a QDDP shared caseloads and office space. Reportedly, this had a significant impact on integrated planning. Unfortunately, due to loss of two nurse case managers (positions which, the Facility informed the Monitoring Team, are unlikely to be filled), this could no longer occur.<br><br>The Monitoring Team attended annual ISP planning meetings for Individuals #61 and #141 and reviewed the resulting ISPs and the assessments prepared for the ISP planning. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • As reported in Provision F1c, assessments for the ISP were still not consistently completed on a timely basis. The expectation, per policy, had been that assessments were to be posted no later than ten days prior to the meeting, such that all team members could review the findings and recommendations in preparation for the meeting. When assessments are not completed and posted timely, IDT members do not have the opportunity to review assessments from other disciplines in order to prepare for the ISP meeting. This may limit integrated planning as not all IDT members have the information that would be needed. This was the case for both the observed ISP planning meetings.<br>• Discussion during the meetings involved most disciplines. The discussion about selection of a more integrated setting in the meeting for Individual #141 included active participation across the IDT. However, the selection of goals for training and of services primarily involved specific disciplines recommending a goal or service with little discussion. One active discussion involved the goal recommended by the Speech Language Pathologist for Individual #141 to identify a dollar. This did not come up in the context of the appropriateness of this goal as a communication goal, or even as a money management goal, but instead was raised during a discussion of whether to restrict the individual's right to keep money. While it was a positive finding that an assessment and recommendation by a clinician would affect the decision-making about restrictions of rights, it is questionable how identifying a dollar would serve as an appropriate communication goal. The assessment identified the individual's communication skills but did not indicate how those could be expanded other than by identifying a dollar, and other members of the IDT did not question this.<br><br>The Facility provided an agenda of the Integration of Clinical Services Quarterly Meeting of 8/29/12. This agenda included notes of follow-up from a meeting of 4/17/12 that included a statement that an Adverse Drug Reaction reporting process was developed at the meeting.. This process was attached. As a positive finding, this interdisciplinary group worked together to develop this process. However, the process provided in the attachment was not itself integrated in nature. Although several disciplines were involved in the process (DSPs, nursing, PCP) and notice was provided to others, each discipline had specific steps to do and pass off to the next, with no steps requiring joint review. | |
| 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- | RGSC Policy 400-14 Medical Care had been revised in July 2012 to require that recommendations from consultant physicians be reviewed by the PCP, documentation included in the medical record, and a copy of the consult form be provided to the QDDP and reviewed by the IDT. The Facility did not provide, and the Monitoring Team did not identify, a similar policy requirement for other clinical disciplines. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 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 through the use of the RGSC Referral/Consultation Form. This form included information about the consultant and/or service, reason for consultation, requesting physician, a place for the consultant to write findings and recommendations, documentation of physician/date/time reviewed, a checkbox for Agree/Accept or Disagree, Do NOT accept, and a place for comments. A prompt that might be helpful is a box to identify if the IDT is being notified.<br><br>The Monitoring Team reviewed 12 medical consultation reports for Individuals #1, #8, #46, #47, #72, #81, and #118, and MBSS consultation reports for Individuals #26, #60, #79, and #98. The physician documented review of all consultations except for one; for Individual #72, there was no documentation of review. Six of the 12 medical consultation reports (50%) also had documentation in the Integrated Progress Notes (IPN). Six medical consultation reports (50%) had documentation that the Facility physician accepted the recommendation and five (42%) had no documentation; as noted above, one had no documentation of review. Four of four MBSS consultations (100%) had documentation of review. Three of the four MBSS consultations (75%) included documentation that the Facility clinician accepted the recommendations; one (25%) had documentation the recommendations were rejected, and also had documentation that a rationale or alternative plan was provided. No medical or MBSS consultations (0%) included documentation that recommendations were referred to the IDT.<br><br>Physician Progress Notes in the CWS serve as the physician's integrated progress note. The Facility provided a sample note. This sample included a note describing the consultation and findings, a plan that apparently was the consultant's recommendation, and a statement by the Facility physician of agreement with the plan. It did not include a statement of whether to refer recommendations to the IDT.<br><br>The minutes of the Team Integration Meeting of 7/17/12 documented discussion of how the IDT should be notified of consultations. A decision was made that the QDDPs will make a copy of the consults to review during morning medical meetings, as they already receive them. It was further decided that consults without recommendations will be reviewed at the morning medical meeting and documented on minutes, and that consults with recommendations will be reviewed, documented on the minutes, and the team will decide if an ISPA is warranted (but these minutes then said an ISPA is needed for all consults with recommendations). Therefore, it seems the IDT was expected to review all consultations, but neither ISPAs nor other evidence was provided to the Monitoring Team that this occurred. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | An additional issue involved dentistry. The Facility did not employ a dentist, and dental services were provided by appointment with community dentists. The Community dentist maintains original dental progress notes, assessments, and diagnostic results, and does complete a dental consultation report, and provided a copy of the dental progress/treatment record for individuals seen at their dental office. The Monitoring Team reviewed all dental consultations reports and dental progress notes completed by the community dentist in March, and in July, 2012. The Monitoring Team noted that in each case the dental consultation report was completed appropriately, and provided a description of dental services, and the dental progress notes were completed. However, no documentation indicated review of these consultation reports by a Facility clinician or referral to the IDT for review. | |

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

1. Determine and describe organized plans for specific actions to progress toward compliance. (Self-assessment)
2. 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)
3. 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)
4. Ensure assessments are developed timely and posted for review by IDT members in preparation for annual ISP planning meetings. (Provision G2)
5. 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. (Provision G2)

| 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:**<br>**Documents Reviewed:**<br>1. RGSC Self-assessment CV 5 dated 8/13/12<br>2. RGSC Action Plans CV 5 dated 8/9/12<br>3. RGSC Entrance Presentation handout<br>4. DADS draft policy #005: Minimum and Integrated Clinical Services 1/12/10<br>5. RGSC SOP ICF-IID 400-14 Medical Care July 2012<br>6. Annual Assessments Filed Within 10 Days document<br>7. ISPs, assessments, CLDPs, and other documents reviewed by members of the Monitoring Team, as identified in other sections of this report<br>**People Interviewed:**<br>1. Group interview of Lorraine Hinrichs (ICF-DD Director), David Moron, M.D. (Clinical Director), and Juan Gonzalez (Program Improvement Specialist)<br>**Meeting Attended/Observations:**<br>1. Team Integration Meeting 8/29/12 |
| | **Facility Self-Assessment:**<br>The Facility provided a self-assessment and action plans. For the self-assessment, the Facility reported for each provision the activities engaged in to conduct the self-assessment, results of the self-assessment, and a self-rating with rationale for the rating.<br><br>The self-assessment used data to provide information on status of assessments, monthly reports, and individualization of aspiration trigger forms, and on audits of diagnoses. The inclusion of such data is welcome and indicates the Facility has begun to identify useful quality assurance measures that can provide information on status of compliance. The Facility reported in several provisions that clinical indicators were not yet being used.<br><br>The Facility assessed that it was in substantial compliance with Provision H2 but not with any other provision of this Section. The Monitoring Team concurs.<br><br>Most action plans were described as "In Process" with two that had not been started. These were actually descriptions of ongoing processes rather than identification of particular outcomes needed for compliance and a sequential plan of action to reach each outcome, although it was clear in discussions with Facility staff that some actions were planned. The Facility should determine and describe organized plans for specific actions to progress toward compliance. An example is for Provision H4, for which the action plan is to identify, track, and aggregate clinical indicators and flag emerging issues during risk assessment. To accomplish this, the Facility might develop a plan to identify what clinical indicators it has already identified and included in compliance assessment and quality assurance, identify procedures to maintain data and to update the list of indicators, then to develop and implement a process to track indicators, then |

| | |
|---|---|
| | to develop and implement a procedure to aggregate and report indicators, and so on. An organized plan, although it might be revised as needed, will help the Facility determine priorities for action, take needed actions, assess the effectiveness of actions, and ensure all needed steps are taken. |
| | **Summary of Monitor's Assessment:**<br>There had been modest progress in most areas of this Section. Comprehensiveness of assessments had improved for some disciplines but not others, timeliness of assessments and implementation of treatments remained problematic, and there had been limited development and use of systemic clinical indicators of health status.<br><br>Provision of assessments on both a regular basis and in response to change in health or behavioral status was not consistent across all disciplines; however, the Monitoring Team noted improvement in comprehensiveness of assessments.<br><br>Diagnoses were consistent with the current versions of the DSM and ICD classification systems, and were generally consistent with the supporting assessments.<br><br>The Facility did not have procedures in place to ensure or monitor that treatments and interventions were implemented timely. There were examples in which treatments and interventions were not provided timely or were not clinically appropriate based upon assessments and diagnoses.<br><br>The Facility had continued to develop systemic clinical indicators of efficacy of treatments and interventions in health care and other clinical areas. Some of these indicators had become integrated into the key indicators used by the Facility for quality review, such as injury and restraint data. However, this remained in early stages.<br><br>The Facility had begun processes to monitor health status of individuals. Assessing acute medical conditions was occurring more proactively and promptly, and consultations were being provided more assertively.<br><br>Improvement is needed in using clinical indicators to determine the need for revision in treatments, particularly in clinical areas other than medical care.<br><br>Policy to identify common elements of clinical care and to provide guidance continues to need development and implementation. |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| H1 | Commencing within six months of the Effective Date hereof and with full implementation within two | Provision of assessments on both a regular basis and in response to change in health or behavioral status was not consistent across all disciplines. Data provided by the Facility indicated a need for improved timeliness. It is important for the assessments to be | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 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. | 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.<br><br><u>Timeliness and Comprehensiveness of Regular Assessments</u><br>In assessing this provision, the Monitoring Team relied primarily on a list provided by the Facility labeled "Annual Assessments Filed Within 10 Days." The Facility reported these data represented discipline assessments being in (or not) the shared drive 10 days before an Individuals ISP meeting as required by policy. Low levels of compliance were reported--for example, Health Risk Assessment (33%), Functional Skills Assessment (53%), Nutritional Assessment (13%), Speech Assessment (8%), Nursing Assessment (8%), and Personal Focus Assessment (11%).<br><br>There was variation in findings regarding whether there were improvements in comprehensiveness of assessments. Some examples of the status of assessments at the Facility included:<br>• 54% (12/22) of OT/PT evaluations were identified as comprehensive assessments. Evaluations did not contain clear comparative analysis, community placement information, or a clear schedule for future monitoring based upon risk. Moreover, only 59% (13/22) of the assessments were dated as completed ten days prior to the annual ISP meeting.<br>• Based on review of 18 communication assessments, (67%) of individuals had comprehensive assessments. Communication assessments that were not considered to be comprehensive did not include recommendations for direct intervention and/or skill acquisition programs.<br>• Twenty percent of psychological assessments contained findings from an intellectual test administered within the previous five years. Forty percent contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.<br>• Review of annual psychiatric assessments found they were based on current, accurate, and complete clinical and behavioral data; in nine out of ten (90%), the assessments were consistent with generally accepted professional standards of care.<br>• Psychiatric assessments had begun to include behavioral data.<br><br><u>Assessments and Evaluations in Response to Changes in Status</u><br>Assessments were not consistently done in response to a change in status, as the following examples demonstrate: | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • As reported in Provision M1, there was a lack of complete and appropriate nursing assessments in individuals' response to presenting signs and symptoms of changes in status; and/or changes in vital signs and oxygen saturation measurements.<br>• Annual and Quarterly Comprehensive Nursing Assessments were not revised to reflect significant changes in status or new problems until the next assessments were completed.<br>• There was a lack of mental status assessments documented during status changes and/or specific descriptions when individuals were engaging in maladaptive behaviors.<br>• As reported in Provision L1, physical examinations conducted for the annual medical assessment were more comprehensive than in the past.<br><br><u>Use of Information From Assessments</u><br>Further, although there had been improvement in completion of assessments, information from the assessments was not always used in planning services and supports or provided unresolved conflicting information. For example, as reported in Provision S1, there was little indication that the Facility had provided adequate assessment in relation to skill acquisition training. Information in the FSA was not used in selection of goals and training programs; Individual #61 had been provided a skill acquisition program (SAP) for brushing teeth. According to the FSA, however, the individual could already perform many steps of the SAP independently. | |
| H2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems. | Diagnoses were consistent with the current versions of the DSM and ICD classification systems.<br><br>For both medical and psychiatric diagnoses, assessments usually provided adequate supporting information to support diagnoses; however, there instances in which the diagnoses needed to be more specific, and the assessments needed to provide more specificity that could guide treatment planning.<br>• Ten out of 35 (29%) had a descriptive, ICD-9 diagnosis of their seizure disorder.<br>• Zero out of five (0%) listed the specific type of hypertension diagnosis, such as essential hypertension, on the active problem list and within the body of the annual medical assessment, rather than simply stating "hypertension."<br>• The Monitoring Team reviewed the most recent annual medical assessment completed on all individuals who underwent a bone mineral density study during the past six months (Individuals #116, #23, #24, #11, #46, #26, and #15). Of the seven samples, seven out of seven samples (100%) listed appropriate ICD-9 diagnosis.<br>• Twenty out of 20 examples (100%) reviewed by the Monitoring Team noted | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | appropriate DSM diagnoses that were clinically justified by the psychiatrist.<br><br>Diagnoses generally fit the corresponding assessments, but this was not always the case.<br>• Of the following medical assessments, there was no discrepancy between the physical assessments, and diagnostics, with the listed diagnosis (Individuals #63, #140, #86, #3, #133, and# 134 (sample was chosen by selecting all individuals from a list of individuals who were reported to have a diagnosis of hypertension).<br>• For Individual #19, review of x-rays indicated that the individual had significant cervical degenerative spine disease; however, degenerative spine disease was not listed on the current annual medical summary, or current active problem list, and CP was listed as a historical diagnosis, and not a current diagnosis.<br>• For Individual #35, Spasticity, degenerative spine disease, and arthritis were not listed as diagnoses on the annual medical assessment or current active problem list.<br><br>The examples in which diagnoses were not supported by assessments, or in which assessments indicated a diagnosis that was not listed on the annual medical assessment or active problem list, indicate the possibility that diagnoses may not clinically fit assessments and evaluations. Given that this provision had been in compliance at prior compliance visits, these may have been related to sampling based on a greater focus by the Monitoring Team on specific conditions. Therefore, the finding of substantial compliance will remain. However, the Facility needs to develop a process to assess whether all assessment documentation is provided to support diagnoses, including providing rationales for diagnoses, and to increase specificity of diagnoses listed for seizure disorders and hypertension. | |
| 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 did not have procedures in place to ensure or monitor that treatments and interventions were implemented timely. Several provisions of this report provide examples in which treatments and interventions were not provided timely or were not clinically appropriate based upon assessments and diagnoses.<br><br>As reported in Provision L1:<br>• The Monitoring Team reviewed the most recent annual medical assessment completed on all individuals who underwent a bone mineral density study during the past six months (Individuals #116, #23, #24, #11, #46, #26, and #15). Of the seven samples, zero out of seven (0%) included a comprehensive medical action plan for all relevant diagnosed medical conditions<br>• For Individual #35, treatment for H-Pylori, was not initiated until six days after diagnostic confirmation. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | As reported in Provision K9, there was extensive delay between PBSP development and implementation. For five PBSPs in the sample reviewed by the Monitoring Team, the average delay between PBSP development and implementation was 76.4 days, and the average delay between obtaining consent and implementing the PBSP was 60.2 days.<br><br>As reported in Provision C7 for the two individuals who had experienced restraint more than three times in any rolling thirty-day period, the Facility documented a review of biological, medical, and psychosocial factors. However, PBSPs had not been revised based on information from those assessments.<br>• For Individual #61, the most recent PBSP was implemented in September, 2011. Although both physical aggression and self-injury had increased since the PBSP was implemented, the PBSP had not been revised.<br>• For Individual #77, the most recent PBSP had been implemented in October 2011 and was based upon an SFA completed in January 2011. The stated treatment expectations of the program were met in January 2012. Despite increases in behavior resulting in restraint, neither the SFA nor the PBSP were reviewed specifically to determine the need for 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. | The Facility had continued to develop systemic clinical indicators of efficacy of treatments and interventions in health care and other clinical areas. Some of these indicators had become integrated into the key indicators used by the Facility for quality review, such as injury and restraint data. However, this remained in early stages. For example, regarding medical quality improvement, the medical director reported that the Facility did not track or trend specific medical indicators, which would be used to enhance clinical outcomes.<br><br>Certainly, clinical indicators of status were used to make decisions on medical care and on behavioral services. As reported in Provisions J3 and J8, behavioral data were used during the process of psychiatric diagnosis and quarterly review of status. However, as reported in Provision K4, processes for data collection and review need to be improved in order to be sure those data are reliable and valid. | Noncompliance |
| 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 begun processes to monitor health status of individuals. As reported in Provision L1, assessing acute medical conditions was occurring more proactively and promptly, and consultations were being provided more assertively.<br><br>The morning Team Integration meeting also provided a daily process for tracking health status of individuals. Any identified significant changes in status, such as acute conditions identified during the prior day or during overnight call, emergency room | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | visits, hospitalizations, and important lab results, were reported to an integrated group.<br><br>There were, however, problems in monitoring, documenting, and tracking health status, as the following examples show:<br>• The Facility's system for documenting seizure active was so fragmented it was not possible to adequately determine the degree of compliance with the Nursing Protocol: Seizure Management Guidelines. Seizure activity documentation was entered into CWS on a variety of reports. The reports included the Crystal Reports, Medical Observation Inquiry Reports, and Integrated Progress Notes. When cross checking various reports, inconsistencies were found between the different reports. Therefore, compliance with the Nursing Protocol: Seizure Management could not be determined. Considering the fragmentation of the seizure activity data it was questionable how this data could be linked together to get an accurate picture of individuals' seizure status, much less use the data for making clinical decisions. The Facility should ensure consistency in reporting seizure activity data into the Crystal Reports, Medical Observation Inquiry Reports, and the Integrated Progress Notes. Further, the Facility should evaluate the effectiveness of the seizure report system in making clinical decisions.<br>• As reported in Provision O7, based on the review of 14 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.<br>• While PNMPs are reviewed at the 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 are determined to be at an increased risk such as the occurrence or absence of triggers (signs and symptoms associated with physical and nutritional decline that require staff response).<br><br>The risk assessment process had been revised. Because the first two uses of this process occurred in the context of the two ISP planning meetings held during the compliance visit, there was not an adequate sample to permit the Monitoring Team to determine how effective this revised process would be in improving risk assessment and monitoring changes in risk status.<br><br>A policy/protocol did 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 | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | decline in people with chronic health conditions. | |
| 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 in policy or procedure 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. RGSC was also taking steps to develop clinical pathways and practices, had identified a few clinical indicators to track routinely and to use in monitoring individual health status (such as HgA1c for individual with diabetes), and had plans to gather information form other state facilities.<br><br>The requirements of this provision related also clinical disciplines other than medicine. In addition to the clinical pathways and clinical indicators being developed, identification and tracking of clinical indicators are important for making decisions about a wide range of interventions.<br><br>For example, clinical indicators should provide one source of information used in assessment of risk. While some guidelines to be considered did include clinical indicators, two problems existed:<br>• Clinical indicators to be monitored and the frequency were not consistently included or were not adequate to assess progress or lack of progress.<br>• The risk ratings did not consistently include clinical data from all relevant disciplines.<br><br>Also, effect of behavior programs should be evaluated through review of data. As reported in Provision C7(e) and in Section K, this did not always occur.<br>• For Individual #61, the most recent PBSP was implemented in September 2011. Although both physical aggression and self-injury had increased since the PBSP was implemented, the PBSP had not been revised.<br>• For Individual #77, the most recent PBSP had been implemented in October 2011 and was based upon an SFA completed in January 2011. The stated treatment expectations of the program were met in January 2012. Despite increases in behavior resulting in restraint, neither the SFA nor the PBSP were reviewed specifically to determine the need for revision.<br>• For three out of six PBSPs (50%), data graphs indicated that changes in the PBSPs or other interventions had been initiated in response to data trends.<br><br>Another example of a treatment or intervention strategy that should be evaluated against specified indicators is physical and nutritional management (PNM). As reported in Provision O1, identification of clinical indicators in which referral back to the Physical and Nutritional Management Team (PNMT) would be required was not clearly | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | implemented as part of the PNMT review or evaluation process. Examples of clinical indicators may be weight loss below or above a desired threshold, or occurrence of triggers. Identification of these thresholds would allow the PNMT to discharge individuals once stabilized and in turn focus more resources on those in more immediate need. As reported in Provision O7, there was not a system fully in place that clearly monitored the effectiveness of the plan by tracking clinical indicators.<br><br>Another clinical service area for which clinical indicators of progress or regression would provide information needed for decisions is communications therapy (speech and language therapy). As reported in Provision R3 for individuals receiving indirect support from Communication Services, quarterly documentation for zero of three individuals (0%) identified recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress. | |
| H7 | Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H. | 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.<br><br>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).<br><br>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. Determine and describe organized plans for specific actions to progress toward compliance. (Self-assessment)
2. 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)

3. Ensure all required assessments are completed and posted to the Share Drive in time to permit review by IDT members. (Provision H1)
4. Develop a system to identify, track, and aggregate clinical indicators and flag emerging issues. (Provision H4)
5. 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:**<br>**Documents Reviewed:**<br>1. RGSC Self-Assessment 8/13/12<br>2. RGSC Action Plan 8/9/12<br>3. RGSC Section I Presentation Book<br>4. RGSC SOP MR 400-02 At Risk Individuals revised 8/12<br>5. DADS At Risk Policy 6.2 updated 2/18/11<br>6. DADS training outline on At-Risk process<br>7. Records for Individuals #26, #55, #60, #61, #66, #79, #126, #140, #141, and #145<br>8. Records for Sample #1 in Section O<br>P**eople Interviewed:**<br>1. Lorraine Hinrichs, ICF-MR Program Director and Section I Lead<br>2. Juan Miguel Gonzalez, Program Improvement Manager<br>**Meeting Attended/Observations:**<br>1. Incident Management Review Team (IMRT) 8/27/12<br>2. Settlement Agreement Performance Improvement Council (SA-PIC) 8/28/12<br>3. Individual Support Plan (ISP) annual planning meeting for Individuals #61 and #141 |
| | **Facility Self-Assessment:**<br>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 0% and 27%.<br><br>The RGSC Self-Assessment reported that all three provisions in this section of the SA were not in substantial compliance. The Monitoring Team concurs.<br><br>The activities and results of the Facility's self-assessment were general and not sufficiently directed at the specific requirements of each provision. For example, for Provision I.1 the self-assessment did not assess whether or not the Facility had a regular risk screening, assessment and management system that comprehensively addressed all requirements of the State At-Risk policy. The Facility will need to ensure that future self-assessments target each specific requirement of each provision of the SA.<br><br>Similarly, the Action Plan submitted as part of the Facility self-assessment was overly general with target dates far in the future (such as 5/31/13). Only one action step was provided for each provision. In each case the responsible person was noted to be the ICF Program Director. These three action steps did not delineate the series of actions (i.e. separate and sequential action steps) necessary to move the Facility closer to compliance. Doing so would obviously identify other Facility staff who would be responsible for completing action steps, for example, nursing and habilitation therapy staff. |

| | |
|---|---|
| | **Summary of Monitors Assessment:**<br>In its last report the Monitoring Team expressed optimism that recent administrative processes that were described as just having been put in place would lead to improved compliance. This did not turn out to be the case. From this review the Monitoring Team noted:<br>• The Facility did not have a regular risk screening, assessment and management system that appropriately and consistently identified individuals whose health or well-being was at risk.<br>• The compliance rates reported by the Facility through its QA monitoring had not improved, and in fact declined, since the last review.<br>• The Facility seems to have difficulty moving from described policies, plans, and processes to effective implementation.<br><br>The Monitoring Team observed the two ISP planning meetings that were held during the week of the review with mixed results regarding risk review, discussion, and decision-making.<br><br>The Facility did not always adequately respond to individuals who had a change in health status that should have resulted in risk screening, and/or change in risk ratings, and/or the initiation of, or change in, risk action plans.<br><br>The Facility reported it had trained staff in late July on the IDT process for risk assessment that State Office had promulgated some months earlier.<br><br>The Facility had also updated its At-Risk policy (ICF-IID 400 02) in August, 2012 to include revisions associated with the revised State policy. |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| I1 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk. | <u>Facility self-assessment:</u><br>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:<br>1. Review of RGSC At Risk Policy to determine if operationalized.<br>2. Monitoring of At Risk Processes using the Section I Monitoring Tool were completed by the ICF Program Director and QE Nurse to determine compliance with RGSC policy. An At Risk individual was chosen to determine if that individual is being screened, assessed and that person's needs are being identified and met.<br><br>Monitoring of the implementation of: Individualization of Aspiration Trigger Forms, identification of possible adverse drug reactions, consultation results being followed through from the physician to the IDT to the DCP.<br><br>From its self-assessment the Facility determined that: | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 1. Review of policy showed full implementation of operationalized policies was not in place at RGSC.<br>2. Two records were reviewed utilizing the DADS State Office Section I Monitoring Tool. Compliance with At Risk Process were:<br>3/12 = 0% compliance.<br>6/12 = 27% compliance.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision was not in substantial compliance because At Risk processes were not fully implemented as evidenced by Section I Monitoring Tool scores.<br><br>Although numerous processes have been implemented to ensure that clinical integration is occurring throughout the facility, the monitoring of the efficacy of the processes has not been implemented as of this time. For example, although training was completed, a process implemented, and the aspiration trigger forms were implemented the preliminary data reflected that 1 of 9 (11%) forms were individualized.<br><br>In addition, upon review of the forms that were implemented, there were nursing referrals made for possible aspiration triggers, such as coughing, but they were not noted on the aspiration trigger form.<br><br><u>Monitoring Team findings:</u><br>The Facility did not have regular risk screening, assessment and management systems which appropriately and consistently identified individuals whose health or well-being was at risk. The compliance rates reported by the Facility through its QA monitoring had not improved, and in fact declined, since the last review. In the last report by the Monitoring Team it was reported that the compliance rates were 17% and 27%. For this reporting period the self-assessment reported compliance rates of 0% and 27%. In its last report the Monitoring Team expressed optimism that recent administrative processes that were described as just having been put in place would lead to improved compliance. This did not turn out to be the case. These processes, as described to the Monitoring Team, were characterized as a conceptual design that would ensure risk related assessments occurred timely, were coordinated between disciplines, and would result in appropriate risk action plans. It was apparent this process did not effectively move from a conceptual design to an operationalized set of coordinated and consistent activities by Facility staff.<br><br>The Facility reported it had trained staff in late July on the IDT process State Office had promulgated some months earlier. This training was specifically directed at the risk assessment process, including emphasis on discipline assessments being timely and thorough, and methodologies for interdisciplinary discussion and review of assessment | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | data.<br><br>The Facility had also updated its At-Risk policy (ICF-IID 400 02) in August, 2012 to include revisions associated with the revised State policy.<br><br>The Facility did not succeed in moving from described policies, plans, and processes to effective implementation.<br><br>The Monitoring Team reviewed the risk assessment planning associated with six individuals. Based on a review of six (sample #1 from Section O of this report) records of Individuals who were diagnosed with pneumonia, four of six (67%) were noted by the Facility to be at an increased risk of aspiration and none of six (0%) had their risk ratings reviewed upon a change in status which in this case was pneumonia.<br><br>Examples of individuals not being appropriately identified included:<br>• Individuals #35 and #26 were both diagnosed with pneumonia but were not identified as being high risk.<br><br>Individual #60 was diagnosed with pneumonia on 2/27/12 but did not have the risk rating reviewed by the team upon confirmation of diagnosis.<br><br>These findings by the Monitoring Team are consistent with the extremely low compliance rates reported by the Facility in its self-assessment.<br><br>The Monitoring Team observed the two ISP meetings that were held during the week of the review. The meeting for Individual #61 included all appropriate disciplines, very good interdisciplinary exchange, and the use of data in reviewing and discussing risk. The required Risk Level Guidelines were used in the meeting, clinical discussion was appropriate, the QDDP kept the meeting focused, and risk levels were changed as a result of the Individual's change in status and IDT review and discussion. The meeting for Individual #141 did not include all appropriate disciplines (there was no physician, psychologist, or psychiatrist present). While it was not clear that their presence was needed, there was no information presented by the QDDP from which the IDT (and the Monitoring Team) would know who was required to be present at the meeting. The required Risk Level Guidelines were not used in this meeting nor was clinical data presented and discussed. Clinically oriented discussion among team members was minimal.<br><br>Staff present at both ISPs included the actual staff who worked directly with the individual. The individual was present at both meetings. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | This Provision is not in substantial compliance. | |
| 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. | <u>Facility self-assessment:</u><br>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 Facility reported it had engaged in the following activities in conducting its self-assessment:<br>1. Review of RGSC At Risk Policy to determine if operationalized.<br>2. Monitoring of At Risk processes using the Section I Monitoring Tool were completed by the ICF Program Director and QE Nurse to determine compliance with RGSC policy.<br><br>From its self-assessment the Facility determined that:<br>1. Review of policy showed full implementation of operationalized policies was not in place at RGSC.<br>2. Two records were reviewed utilizing the DADS State Office Section I Monitoring Tool. Compliance with At Risk Process were:<br>3/11 = 0% compliance.<br>6/12 = 27% compliance.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision was not in substantial compliance because At Risk processes were not fully implemented as evidenced by Section I Monitoring Tool scores.<br><br><u>Monitoring Team findings:</u><br>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 #26, #60, #79, #126, #140, and #145.<br><br>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 (17%), Individual #26.<br><br>There were two instances (33%) where the interdisciplinary assessment was comprehensive (irrespective of timeliness). This was the case for Individuals #60 and #126.<br><br>Based on a review of records of three individuals (Individuals #126, #140, and #145) for | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | whom assessments had been completed to address the individuals' at risk conditions, none included an adequate nursing assessment to assist the team in developing an appropriate plan. Examples include:<br><br>Individual #145:<br>• The assessment was inadequate to support the risk level determined.<br>• The assessment did not provide adequate information that helped how to address the risk.<br>• There was no evidence that a comprehensive interdisciplinary plan was developed to address the risk.<br>• The plan did not include preventative interventions to minimize the risk.<br>• The plan did not show adequate integration among all appropriate disciplines.<br>• There were no changes in all supports and services relevant to the risk.<br>• The plan did not include adequate functional measurable objectives incorporated into the ISP to measure efficacy of the plan.<br>• The plans did not identify all appropriate clinical indicators to be monitored and frequency of monitoring.<br><br>Individual #140 High risk for falls:<br>• Did not include a comprehensive interdisciplinary assessment.<br>• The assessment was inadequate to support the risk level determined.<br>• The assessment did not provide adequate information that helped how to address the risk.<br>• There was no evidence that a comprehensive interdisciplinary plan was developed to address the risk.<br>• The plan did not show adequate integration among all appropriate disciplines.<br>• There were no changes in all supports and services relevant to the risk.<br>• The plan did not include adequate functional measurable objectives incorporated into the ISP to measure efficacy of the plan.<br>• The plans did not identify all appropriate clinical indicators to be monitored and frequency of monitoring.<br><br>Other examples of deficiencies in risk screening and assessment processes included: Based on a review of six (sample #1 from Section O of this report) records of Individuals who were diagnosed with pneumonia, four of six (67%) were noted by the Facility to be at an increased risk of aspiration and none of six (0%) had their risk ratings reviewed upon a change in status which in this case was pneumonia.<br><br>RGSC was also deficient in adequately responding to individuals who had a change in health status that should have resulted in risk screening and/or change in risk ratings | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | and/or risk action plans. Examples are reported in Provisions M.5 (particularly in relation to aspiration triggers and vomiting) and O.2 of this report.<br><br>This Provision is not in substantial compliance. | |
| 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. | <u>Facility self-assessment:</u><br>RGSC reported in its self-assessment that it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>1. Review of RGSC At Risk policy to determine if operationalized.<br>2. Monitoring of At Risk processes using the Section I Monitoring Tool were completed by the ICF Program Director and QE Nurse to determine compliance with RGSC policy.<br><br>From its self-assessment the Facility determined that:<br>1. Reviews of policy showed full implementation of operationalized policies were not in place at RGSC.<br>2. Two records were reviewed utilizing the DADS State Office Section I Monitoring Tool. Compliance with At Risk Process were:<br>3/12 = 0% compliance.<br>6/12 = 27% compliance.<br><br>Based on the findings of the self-assessment, the Facility determined that this provision was not in substantial compliance. At Risk processes were not fully implemented as evidenced by Section I Monitoring Tool scores.<br><br><u>Monitoring Team findings:</u><br>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 #26, #60, #79, #126, #140, and #145.<br><br>There was documentation that the Facility:<br>• Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate in three of the six cases (Individuals #26, #140, and #145).<br>• Implemented a plan within 14 days that met the needs identified by the IDT assessment in two of the six cases (Individuals #26 and #126).<br>• Included preventative interventions in the plan to minimize the condition of risk in two of the six cases (Individuals #26 and #145).<br>• Of three cases in which the risk to the individual warranted immediate action, | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | the Facility took immediate action in none (Individuals #26, #60, and #79).<br>• Integrated the plans into the ISPs in none of the six cases.<br>• None of the risk plans documented adequate integration between all of the appropriate disciplines, as dictated by the individual's needs.<br>• None documented appropriate functional and measurable objectives .incorporated into the ISP to allow the team to measure the efficacy of the plan.<br>• None documented the clinical indicators to be monitored and the frequency of monitoring.<br><br>This Provision is not in substantial compliance. | |

**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. QDDPs 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:**<br>**Documents Reviewed:**<br>1. RGSC Self-Assessment 8/13/12<br>2. RGSC Action Plan 8/9/12<br>3. RGSC Section J Presentation Book, 8/27/12<br>4. RGSC Procedure on Integration of Psychology and Psychiatry, dated 6/9/12 (no procedure number)<br>5. RGSC Standard Operating Procedure ICF-IID 600 01, Individual Support Plan process<br>6. Most recent annual psychiatric assessment for ten individuals randomly selected by the Facility: Individuals #150, #76, #27, #12, #62, #2, #82, #3, #66, #33<br>7. Most recently completed individual personal support plans (PSP) for ten individuals randomly selected by the Facility: Individuals #150, #76, #27, #12, #62, #2, #82, #3, #66, #33<br>8. Most recent positive behavioral support plan (PBSP) for ten individuals randomly selected by the Facility: Individuals #150, #76, #27, #12, #62, #2, #82, #3, #66, #33<br>9. Ten randomly selected quarterly psychotropic medication reviews for ten individuals randomly selected by the Facility<br>10. Most recent psychiatric assessment, medication list, most recent two MOSES and DISCUS assessments for Individuals #84, #80, #62, #5, #36, #150, #46, #33, #27, and #139<br>11. All Reiss Screens completed during the past six months<br>12. Certification status and continuing medical education (CME) status for psychiatrists<br>13. Ten, quarterly psychotropic medication reviews that were randomly generated by the Facility: Individuals #84, #63, #96, #5, #134, #79, #48, #61, #26, and #97<br>**People Interviewed:**<br>1. Dr. David Moron, Clinical Director, and psychiatrist<br>**Meeting Attended/Observations:**<br>1. Observation of Individuals #27, #12, #62, #2, #82, #3, #66, at their living area |
| | **Facility Self-Assessment:**<br>After review of the Facility's self assessment, and plan of improvement, the Monitoring Team concurred the self-assessment of noncompliance with Provisions J4, J9, J10, J11, J14, and J15.<br><br>The Monitoring Team disagreed with the Facility's self-assessment of noncompliance with Provisions J5, J6, and J12, and determined the Facility to be in compliance with the Provisions. The Facility's self-assessment for Provision J5 indicated that it had not filled a staffing position for the psychiatric services; however, at the time of this review, the Facility had a full time equivalent contract psychiatrist, and a part-time psychiatrist providing direct psychiatric services at the Facility; therefore the Monitoring Team determined that the Facility was in compliance with Provision J5. The Facility determined J6 to be noncompliant because a peer review process was not implemented, and because only 97% of the psychiatric assessments were completed as described in Appendix B. The Monitoring Team determined psychiatric assessment were completed as described in Appendix B in 90% of samples reviewed and that assessment utilized |

| | |
|---|---|
| | behavioral data and provided accurate assessments to justify diagnosis and treatment in 100% of the samples; therefore, the Monitoring Team determined the Facility to be in substantial compliance with Provision J6. The Facility based its self-assessment of non-compliance with Provision J12 because it claimed that despite the psychiatrist reviewing all MOSES and DISCUS, there was not way to verify compliance. The Monitoring Teams assessment of Provision J12 indicated that MOSES and DISCUS were completed timely and more frequently when clinically indicated, and that they were appropriated reviewed and an action plan documented for abnormal findings, when clinically appropriate, there fore the Monitoring Team determined that the Facility was in substantial compliance with Provision J12.<br><br>The Monitoring Team did not concur with the Facility self-assessment of substantial compliance with Provision J8. Although the Facility had made progress by implementing a process for integrated planning between psychologists and psychiatrists, the self-assessment did not review (and the Facility did not provide) evidence that planning was consistently integrated.<br><br>The Monitoring Team disagreed with the Facility self-assessment of substantial compliance with provision J13. The Facility noted that it was in compliance because ISP documentation reflected the integration of psychology and psychiatry services as outline in Provision J13. The Monitoring team noted that treatment plans did not effectively delineate prognosis, timelines for expected efficacy, and who should monitor expected clinical outcomes. In general, action plans did not delineate specific steps that would lead to system improvement and address requirements of each Provision. |
| | **Summary of Monitor's Assessment:**<br>The Monitoring Team noted continued and significant progress towards substantial compliance with Provision J of the Settlement Agreement. The Facility maintained adequate staffing for psychiatric services, through a full time equivalent contract psychiatrist that was fully supported by the clinical director, who provided backup and ten hours of direct psychiatric services per week. Psychiatric assessments included robust use of behavioral data to support both diagnosis, and treatment strategies. Psychologists, nurses, and psychiatrists participate in meaningful personal support team meetings to review, and develop treatment strategies that meet standard of care practices.<br><br>Provision J1: Because the Treating psychiatrists have been trained in general psychiatry, have had experience working with individuals with intellectual disabilities, are current with CME , and because there was appropriate staffing of psychiatric services, the Monitoring Team determined that the Facility remained in substantial compliance with Provision J1.<br><br>Provision J2: Because the Facility ensures that all psychotropic medications are appropriately prescribed, and that each individual's prescribed psychotropic medications are carefully evaluated by a psychiatrist, who assigned a clinically justifiable diagnosis, the Monitoring Team determined that the Facility is in substantial compliance with Provision J2.<br><br>Provision J3: Although there was no indication that the Facility utilized psychotropic medications as a form of punishment, and the Facility provided a comprehensive psychiatric assessment, which included |

| | |
|---|---|
| | appropriate diagnosis, that was clinically justifiable, and that psychotropic treatment regimens were appropriate for each clinical case reviewed. Nevertheless, the Facility did not yet demonstrate that medications were not used as a substitute for a treatment program. Therefore, the Monitoring Team concluded that the Facility was not in compliance with Provision J3.<br><br>Provision J4: Because the Facility had yet to develop strategies to address the review of pre-treatment sedation, and to develop meaningful strategies to help mitigate the use of pre-treatment sedations, the Monitoring Team determined that the Facility is noncompliant with Provision J4.<br><br>Provision J5: Because each of the annual psychiatric assessments reviewed indicated that current, accurate, and complete clinical and behavioral data was used during the assessment process, and because the psychiatric assessment followed the requirements of Appendix B of the Settlement Agreement, the Monitoring Team determined that the Facility is in substantial compliance.<br><br>Provision J6: Because each of the annual psychiatric assessments reviewed indicated that current, accurate, and complete clinical and behavioral data was used during the assessment process, and because the psychiatric assessment followed the requirements of Appendix B of the Settlement Agreement, the Monitoring Team determined that the Facility is in substantial compliance.<br><br>Provision J7: Because the Facility maintained the same practice standard as for the previous Monitoring Team review, the Monitoring Team will continue substantial compliance; however, subsequent compliance will require the Facility to ensure that Reiss screens are administered to all individuals who experience new onset maladaptive behaviors.<br><br>Provision J8: Although the Facility developed and implemented a robust process that helps to ensure collaboration among psychologist, and psychiatrist to include behavioral data in the psychiatric assessments, and to consider and review non-pharmacological treatments, the Monitoring Team could not confirm that this had resulted in integrated planning and determined noncompliance with Provision J8.<br><br>Provision J9: The Monitoring Team noted that the Facility initiated a process, Integration of Psychology and Psychiatry, whereby the psychiatrist and psychologist meeting in the context of an IDT setting, to review. Review of psychiatric assessments indicate significant improvement, and clearly delineate noted behavioral challenges, and non-pharmacological approaches to managing such challenges. However, ISPs, PBSPs, and psychiatric documentation did not provide statements that clearly documented the IDT had considered the proposed treatment program and made efforts to assure the program used the least intrusive and most positive interventions. Documentation must clearly specify the rationale for selection of interventions.<br><br>Provision J10: Because the Facility did not discuss alternate treatment options during quarterly psychotropic medications, the Monitoring Team concurred with the Facility and determined that it is not in compliance with Provision J10. Compliance will require that all risks and benefits, and alternate treatment, including no treatment, be well documented on all IDT reports and the ISP, when discussing psychiatric |

| | |
|---|---|
| | issues, and that these issues be reviewed by the IDT prior to initiating any non-emergency use of psychotropic medications. It is essential that the nurse, psychologist, psychiatrist and primary care physician participate in the review process.<br><br>Provision J11: The Monitoring Team concurs with the Facility's self-assessment, and determined it to be noncompliant with Provision J12. Compliance will require the development and implementation of a system to monitor, at least monthly, the prescriptions of intraclass polypharmacy of two or more psychotropics, and anyone on three or more psychotropics regardless of class, and ensure that there is clinical rationale documenting the use of polypharmacy, and when appropriate, ensure that there is a medication reduction plan in place.<br><br>Provision J12: Because MOSES and DISCUS assessments were obtained when necessary, completed appropriately, and demonstrated appropriate review and follow-up by the psychiatrist, the Monitoring Team determined that the Facility was in substantial compliance with Provision J12.<br><br>Provision J13: The Monitoring Team determined that the Facility is not in compliance with Provision J13. Compliance will require that a formal policy and procedure be developed that outlines the process for psychotropic medication treatment plans, ensures that the expected timeline for the therapeutic effects of the medication to occur is stated, and delineates by whom, how, and when monitoring for efficacy should occur.<br><br>Provision J14: Because there has been no improvement with regards to developing a more meaningful consent process that requires direct discussion with the LAR, and clear delineation of risks, benefits, and alternative treatments, including no treatment, the Monitoring Team determined that the Facility remains not in compliance with Provision J14. Compliance will require a consent process that demonstrates discussion between the LAR and psychiatrist; clear delineation of risks, benefits, and alternative treatments; timely acquisition of consents for both emergency and non-emergency situations requiring the administration of psychotropic medications; indication whether the medication is FDA or not FDA approved; clinical indication for use of a psychotropic medication; expected benefits, side effects, documentation of review by human rights committee; and any limitations on the use of the medication.<br><br>**Provision J15:** The Monitoring Team determined that the Facility was not in compliance and must develop and implement a process that ensures that neurologist and psychiatrists collaborate when prescribing antiepileptic drugs for combined psychiatric and neurologic conditions. Such collaboration must be reflected on relevant psychiatric assessments and psychotropic medication reviews. |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| J1 | Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified | The Facility employs a board certified psychiatrist, who serves as the Facility's Clinical Director, and provides 10 hours of psychiatric services per week. In addition, the Facility has contracted with a full time board certified psychiatrist with experience in serving | Substantial Compliance |

| | | | |
|---|---|---|---|
| | professionals. | individuals with intellectual disabilities, who provides direct psychiatric care, until a full time psychiatrist can be hired by the Facility. The Facility continues to assertively recruit for a permanent, full time psychiatrist. The Facility conducts each psychiatric assessment, at an IDT meeting, during which time all members of the IDT are invited to the meeting, including the nurse and primary care physician. Such meetings are conducted at least quarterly, and more often when necessary. Additionally, the clinical director, who is a psychiatrist participates at the annual personal support plan (PSP) meeting for Individuals who are prescribed psychotropic medications.<br><br>Because psychiatric services are provided by qualified psychiatrists, the Monitoring Team continues substantial compliance for 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. | By review of ten psychiatric evaluations that were randomly selected by the Facility, the Monitoring Team determined that all ten (100%), were completed by a board certified psychiatrist; ten out of ten (100%) demonstrated the use of behavioral data to aid in justifying the use of psychotropic medications; ten out of ten (100%) demonstrated that the evaluation was comprehensive, and appropriate. Note, though, that although the psychiatrist reviewed the behavioral data that was available, those data (as reported in Provision K4, were not demonstrated to be reliable or sufficient to assess progress.<br><br>The Monitoring Team determined that the Facility reviewed annual psychiatric assessment recommendations in ten of ten examples (100%).<br><br>No individuals had NOS diagnoses.<br><br>Because the Facility ensures that all psychotropic medications are appropriately prescribed, and that each individuals prescribed psychotropic medications are carefully evaluated by a psychiatrist, who assigned a clinically justifiable diagnosis, the Monitoring Team determined that the Facility is in substantial compliance with Provision J2. | 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 | Review of ten annual psychiatric assessments, and ten quarterly psychotropic medication reviews, which were randomly chosen by the Facility, indicated that in 20 out of 20 examples (100%) there was documentation of an appropriate treatment plan; 20 out of 20 examples (100%) noted appropriate DSM diagnosis that were clinically justified by the psychiatrist; behavioral data was reviewed and used to justify the diagnosis, and use of psychotropic medication in 20 out of 20 samples (100%); in no cases were psychotropic medications used as a punishment; all annual psychotropic medication reviews and annual psychiatric assessments are completed at an IDT meeting, and nurses, and the psychiatrist were present at 20, out of 20 examples.<br><br>However, as reported in Provision K9, although there had been great improvement in the content of Positive Behavior Support Plans (PBSPs) and in the Structural and Functional | Noncompliance |

| | | | |
|---|---|---|---|
| | be used as punishment. | Assessments (SFAs) they were based on, only six had been completed using a new process and format. Furthermore, as reported in Provision K11, no system was in place for ongoing monitoring of treatment integrity (that is, to show that treatments and services were being provided as designed). As reported in Provision K8, no individuals received psychological services other than a PBSP. Therefore, it was unclear whether all individuals were provided treatment that would be adequate to confirm that medications were not used as a substitute for a treatment program.<br><br>Although there was no indication that the Facility utilized psychotropic medications as a form of punishment, and the Facility provided a comprehensive psychiatric assessment which included appropriate diagnosis that was clinically justifiable, and that psychotropic treatment regimens were appropriate for each clinical case reviewed, the lack of other treatment modalities such as a PBSP that met current standards, or counseling, mean that the Facility did not yet demonstrate that medications were not used as a substitute for a treatment program. Therefore, the Monitoring Team concluded that the Facility was not in compliance with Provision J3. | |
| J4 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects. | The clinical director informed the Monitoring Team that the Facility had yet to develop a process that assesses the use of pre-treatment sedation for dental and medical procedures, nor has it effectively developed strategies to minimize the use of such treatments.<br><br>Because the Facility had yet to develop strategies to address the review of pre-treatment sedation, and to develop meaningful strategies to help mitigate the use of pre-treatment sedations, the Monitoring Team determined that the Facility is non-compliant with Provision J4. | Noncompliance |
| 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 | At the time of this review, the Facility had a full time equivalent psychiatrist who was contracted to the Facility to provide psychiatric services at the Facility. Additionally, the clinical director provided an additional ten hours of psychiatric services each week. Based on the total number of 19 individuals who the Facility reported require psychiatric services, the clinical director, and the consulting psychiatrist concur that they are able to provide necessary clinical services to individual requiring psychiatric supports. | Substantial Compliance |

| | | | |
|---|---|---|---|
| | ensure the provision of services necessary for implementation of this section of the Agreement. | | |
| J6 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B. | Review of the annual psychiatric assessments for Individuals #150, #76, #27, #12, #62, #2, #82, #3, #66, #33, which were randomly chosen by the Facility, the Monitoring Team noted that in ten of the ten samples (100%) were based on current, accurate, and complete clinical and behavioral data; in nine out of ten (90%), the assessments were consistent with generally accepted professional standards of care, as delineated in Appendix B of the Settlement Agreement; and in nine out of ten (90%) of the samples the Individual's record displayed the psychiatric assessment following every component in the format in Appendix B of the Settlement Agreement, including history, review of current medications and changes during the prior year, allergies and relevant lab results, mental status exam, and a rationale for selection of the diagnosis. The only item not addressed was any spiritual issues in the context of a bio-psycho-social-spiritual formulation.<br><br>Because each of the annual psychiatric assessments reviewed indicated that current, accurate, and complete clinical and behavioral data was used during the assessment process, and because the psychiatric assessment followed the requirements of Appendix B, in the Settlement Agreement, the Monitoring Team determined that the Facility is in substantial compliance. | Substantial Compliance |
| J7 | Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment 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 | The Monitoring Team reviewed all Reiss screens completed during the past six months, as well as the psychiatric assessments of three individuals (#88, #98, and #60), who were referred to the psychiatrist because of behavioral exacerbations, who were not being followed by the psychiatrist. The Monitoring Team also requested written response asking if Reiss screens were completed on individuals who experienced behavioral changes, and were currently being followed by the psychiatrist.<br><br>The Monitoring Team determined that the Facility continued to offer the Reiss screen annually to all individuals at the Facility who were not followed by the psychiatrist, and to all new admissions to the Facility. There were no incidences of positive Reiss screens during the past six months. The written response by the Facility regarding the application of the Reiss screen for those who experience a behavioral exacerbation indicated that the Facility did not routinely provide Reiss screens for such instances. Also, for the three individuals referred for psychiatric evaluation (#88, #98, and #60), a Reiss screen was not completed subsequent to the behavioral exacerbation.<br><br>Because the Facility maintained the same practice standard as for the previous Monitoring Team review, the Monitoring Team will continue substantial compliance; however, subsequent compliance will require the Facility to ensure that Reiss screens are administered to all individuals who experience new on-set maladaptive behaviors. | Substantial Compliance |

| | | | |
|---|---|---|---|
| | assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner. | | |
| J8 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. | To assess compliance for Provision J8, the Monitoring Team discussed, with the clinical director, the Facility's process to integrate pharmacological treatment with behavioral and other interventions, reviewed a procedure entitled Integration of Psychology and Psychiatry, which was dated 6/9/12 (no procedure number), reviewed a schedule documenting meetings among the psychologist and psychiatrist when they discussed diagnostic and treatment integration, and reviewed ten quarterly psychotropic medication reviews, that were randomly selected by the Facility (individuals #84, #63, #96, #5, #134, #79, #48, #61, #26, and #97).<br><br>The Procedure on Integration of Psychology and Psychiatry clearly delineated a process when the psychologist and psychiatrist would regularly meet, on Tuesdays and Thursdays of week, to review clinical indications, behavioral data, and pharmacological and non-pharmacological treatments. In addition, the nurse, psychiatrist, and psychologist attend every annual psychiatric assessment, and quarterly medication review. Review of the psychology/psychiatric meeting log documented the presence of the psychologist and psychiatrist, as scheduled.<br><br>Review of ten quarterly psychotropic medication reviews, the Monitoring Team noted that behavior indications and data were well incorporated into the assessments, and that a nurse and psychologist participated at the reviews in ten out of ten cases (100%); non-pharmacological treatment plans was commented on in ten out of ten (100%) of the samples.<br><br>Nevertheless, it was unclear that adequate integration occurred. Other than a brief, general discussion in the SFA, the Monitoring Team received no documents from Psychology demonstrating the integration of psychiatry and psychology. There was no discussion of behavioral correlates of mental health diagnoses in the SFAs and no indication of any attempts to identify what symptoms might be under environmental control. Although there was a schedule of psychologist/psychiatrist meetings, there was little to suggest that these meetings, or other interactions with psychiatry, were used to guide behavior assessments or formulate behavior interventions.<br><br>Although the Facility developed and implemented a robust process that helps to ensure collaboration among psychologist and psychiatrist to include behavioral data in the psychiatric assessments, and to consider and review non-pharmacological treatments, it was unclear that this actually led to adequate integration yet. Therefore, the Monitoring Team concurs with the Facility's self-assessment and determined compliance with Provision J8. | 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. | To determine if the Facility maintains a process by which the psychiatrist and psychologist meet in the context of and IDT to ensure that the least intrusive and most positive interventions to treat behavior or psychiatric conditions, the Monitoring Team requested the last ten psychiatric assessments that were completed for June, July and August 2012, along with associated behavioral support plans, and Facility's policy for integrating pharmacological and behavioral treatments.<br><br>The Monitoring Team noted that the Facility initiated a process, Integration of Psychology and Psychiatry, whereby the psychiatrist and psychologist meeting in the context of an IDT setting, to review. This process requires that the psychiatrist and psychologist meet on two days of each week, and are to review behavioral data, and to determine a treatment plan, based on the least restrictive, and most positive approach. Each treatment plan is then to be reviewed by the positive behavior support peer review committee, prior to being implemented. Documentation from this process was not reviewed; the Monitoring Team looks forward to reviewing such documentation at the next compliance visit.<br><br>Review of the 30 psychiatric assessments provided for review indicate significant improvement, and clearly delineate noted behavioral challenges, and non-pharmacological approached to managing such challenges in 30 out of 30 examples (100%). The assessment also reviewed tracked data in all 30, out of 30 examples (100%).<br><br>However, ISPs, PBSPs, and psychiatric documentation did not provide statements that clearly documented the IDT had considered the proposed treatment program and made efforts to assure the program used the least intrusive and most positive interventions. Documentation must clearly specify the rationale for selection of interventions. | 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 | To assess if the Facility had a system in place that helps to ensure the administration of non-emergency psychotropic medications are reviewed by the IDT process, the Monitoring Team reviewed ten quarterly psychotropic medication reviews, that were randomly selected by the Facility (Individuals #84, #63, #96, #5, #134, #79, #48, #61, #26, and #97), and the Facility's Standard Operating Procedure ICF-IID 600 01, Individual Support Plan Process.<br><br>Review of the Facility's Standard Operating Procedure ICF-IID 600 01, Individual Support Plan process indicated that the Facility was to ensure that psychiatric assessment and the quarterly psychotropic medication reviews were conducted in the context of an IDT meeting, during which time, the entire team was to be invited.<br><br>Review of the ten quarterly psychotropic medication reviews, that were randomly | Noncompliance |

| | | | |
|---|---|---|---|
| | alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications. | generated by the Facility, indicated that a nurse, psychiatrist, and psychologist were present at the reviews in ten out of ten samples (100%); in zero out of ten samples (0%) was there documented evidence to support that Facility reviewing alternate treatments; risks and benefits of psychotropic medications were efficaciously addressed in zero out of ten samples (0%)<br><br>Because the Facility did not discuss alternate treatment options during quarterly psychotropic medications, the Monitoring Team concurred with the Facility and determined that it is not in compliance with Provision J10. Compliance will require that all risks and benefits, and alternate treatment, including no treatment, be well documented on all IDT reports and the ISP, when discussing psychiatric issues, and that these issues be reviewed by the IDT prior to initiating any non-emergency use of psychotropic medications. It is essential that the nurse, psychologist, psychiatrist and primary care physician participate in the review process. | |
| 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. | To determine the effectiveness of the Facility's process to review polypharmacy, the Monitoring Team discussed its process with the clinical director, and reviewed the Facility's self-assessment, and action plan. In addition, the Monitoring Team reviewed the assessment of Provision N3, of this report, which also calls for a process to review polypharmacy.<br><br>The Clinical Director informed the Monitoring Team that the Facility had yet to develop and implement an effective mechanism to review polypharmacy, and the Facility's self-assessment indicated that the psychiatrist had not been involved in attendance at meetings designed to establish a polypharmacy review process.<br><br>However, minutes of the past six months of P&TC and polypharmacy meetings reflected that individuals were being reviewed on an individual basis, and formal recommendations were being provided, as necessary. The Monitoring Team noted that there was excellent review of data and trends of the Facility's use of polypharmacy, and that the use of polypharmacy had significantly decreased during the past 12 months.<br><br>The Monitoring Team concurs with the Facility's self-assessment, and determined it to be noncompliant with Provision J11. Compliance will require the development, and implementation of a system to monitor, at least monthly, the prescriptions of intraclass polypharmacy of two or more psychotropic medications, and anyone on three or more psychotropics regardless of class, and ensure that there is clinical rationale documenting the use of polypharmacy, and when appropriate, ensure that there is a medication reduction plan in place. | Noncompliance |
| J12 | Within six months of the Effective Date hereof, each Facility shall | The Monitoring Team reviewed the psychiatric assessments, most recent two MOSES, and most recent two DISCUS assessments, of the most recent ten individuals who | Substantial Compliance |

| | | | |
|---|---|---|---|
| | 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. | recently had either a neuroleptic medication added, discontinued or dose change. Of the 40 assessments reviewed, 40 out of 40 (100%) were completed timely, and more frequently when clinically indicated; 39 out of 40 (98%) were completed appropriately; 39 out of 40 (98%) demonstrated appropriate recommendations for abnormal findings, and were followed, and documented by the psychiatrist; 37 out of 40 (93%) were reviewed and completed within seven days (usually the same or next day) by the psychiatrist.<br><br>Because MOSES and DISCUS assessments were obtained when necessary, completed appropriately, and demonstrated appropriate review, and follow-up by the psychiatrist, the Monitoring Team determined that the Facility was in substantial 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 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 clinical director informed the Monitoring Team that each annual psychiatric assessment and quarterly psychotropic medication review is completed in the context of an IDT, (as confirmed through review of attendance signature sheets) that always includes a nurse, psychologist, and psychiatrist. Furthermore, the primary care physician either attends the IDT, or can participate by telephone, depending on the relevance of the case. Through review of ten annual psychiatric assessments, and ten quarterly psychotropic medication reviews, that were randomly selected by the Facility, the Monitoring Team noted that 19 out of 20 (95%) of the sample included a treatment plan that provided clinically justifiable diagnosis, objective psychiatric symptoms, and enabled timely reviews; 0 out of 20 (0%) of the samples included expected timelines for therapeutic effects of the medication to occur, or listed whom, when, and how monitoring will occur.<br><br>The Monitoring Team determined that the Facility is not in compliance with Provision J13. Compliance will require that a formal policy and procedure be developed that outlines the process for psychotropic medication treatment plans, ensures that the expected timeline for the therapeutic effects of the medication to occur is stated, and delineates by whom, how, and when monitoring for efficacy should occur. | Noncompliance |
| J14 | Commencing within six months of the Effective Date hereof and with full implementation in one year, | Through interview with the clinical director, the Monitoring Team learned that the Facility had not enhanced the consent process since the last compliance visit and that a new consent process will be developed for the next Monitoring Team review. The | Noncompliance |

| | | | |
|---|---|---|---|
| | 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. | Facility continues to use previous versions of their consent form, which is nothing more then a checkoff list, and does not ensure that the psychiatrist make direct contact with the legally responsible person, and did not specify risks, and benefits or treatments versus alternative treatments, including no treatment.<br><br>Because there has been no improvement with regards to developing a more meaningful consent process that requires direct discussion with the LAR, and clear delineation of risks, benefits, and alternative treatments, including no treatment, the Monitoring Team determined that the Facility remains not in compliance with Provision J14. Compliance will require a consent process that demonstrates discussion between the LAR and psychiatrist; clear delineation of risks, benefits, and alternative treatments; timely acquisition of consents for both emergency and non-emergency situations requiring the administration of psychotropic medications; indication whether the medication is FDA or not FDA approved; clinical indication for use of a psychotropic medication; expected benefits, side effects, documentation of review by human rights committee; and any limitations on the use of the medication. | |
| 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 clinical director reported that psychiatrists and neurologists do not collaborate on cases that involve the use of antiepileptic drugs for combined psychiatric and neurological conditions. The Monitoring Team was made aware that the Facility is in the process of contracting with a neurologist to participate in such clinical reviews.<br><br>The Monitoring Team determined that the Facility was not in compliance and must develop and implement a process that ensures that neurologist and psychiatrists collaborate when prescribing antiepileptic drugs for combined psychiatric and neurologic conditions. Such collaboration must be reflected on relevant psychiatric assessments, and psychotropic medication reviews. | Noncompliance |

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

1. Develop and implement strategies to address the review of pre-treatment sedation, and to develop meaningful strategies to help mitigate the use of pre-treatment sedation. (Provision J4)
2. Develop and implement a policy and procedure that outlines the process for psychotropic medication treatment plans, ensures that the expected timeline for the therapeutic effects of the medication to occur is stated, and delineates by whom, how, and when monitoring for efficacy should occur. (Provision J13)
3. Revise the consent process for psychiatric treatments to reflect recommendations stated in Provision J14, of this report. (Provision J14)
4. Develop and implement a process that ensures that neurologist and psychiatrists collaborate when prescribing antiepileptic drugs for combined psychiatric and neurologic conditions. (Provision J15)
5. Ensure that an IDT considers all risks, benefits and alternate treatment strategies as delineated by the Monitoring Team under J10. (Provision J10)

| |
|---|
| 6. The Facility must develop and implement a process to review polypharmacy. (Provision J11) |

| 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:**<br>**Documents Reviewed:**<br>1. RGSC Self-Assessment (8/13/12)<br>2. RGSC Action Plan (8/9/12)<br>3. RGSC August 2012 Presentation notes<br>4. Minutes for the Peer Review Committee (2/10/2012 – 6/28/2012)<br>5. 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 RGSC Self-Assessment and Action Plan and included Individuals #5, #40, #44, #59, #62, #84, #101, #118, #132, and #134.<br>**People Interviewed:**<br>1. Ruben Nieto, BCBA – Psychology Director<br>2. Vanessa Villarreal, M.Ed. – Interim Psychology Director<br>3. Samantha Salinas, MSW – Contract Associate Psychologist<br>4. Cheryl Fielding, PhD, BCBA – Contract Psychologist<br>5. Alonzo Andrews, M.A., BCBA – Contract Psychologist<br>6. Megan Gianotti, M.Ed., BCBA – Contract Psychologist<br>7. Janie Villa – QDDP Coordinator<br>8. Direct Support Professionals: Approximately 15 staff members in residences, classrooms and vocational settings<br>**Meetings Attended/Observations:**<br>1. Peer Review Committee (PBSC) (8/29/2012)<br>2. Human Rights Committee (HRC) (8/30/2012)<br>3. Quarterly Psychotropic Drug Review (8/27/2012)<br>4. Observations were conducted in all residences, classrooms, vocational settings, and leisure areas on 8/28, 8/29, and 8/30. |
| | **Facility Self-Assessment:**<br>At the time of the site visit, RGSC reported that no provisions were in substantial compliance with the Settlement Agreement. Based upon information obtained during the site visit, it was the conclusion of the Monitoring Team that the Facility was in substantial compliance with Provision K.2. The discrepancy between the self-assessment and the conclusion of the Monitor reflected elapsed time rather than an error by the Facility. At the time of the Self-Assessment, the new director of Behavioral Services had not yet completed new employee orientation. At the time of the site visit, new employee orientation had been completed and the individual was a full employee of the Facility. |

| | |
|---|---|
| | In general, improvement was noted in the organization and presentation of the Self-Assessment. A notable attempt had been made to mirror the tools and processes used by the Monitor. This included comparisons between previous and current self-assessments. In many circumstances, the information presented by the Facility was accurate. There were situations, however, where positive ratings in the Facility Self-Assessment could not be substantiated. For example, the Facility reported that in 100% of reviewed PBSPs there had been input from direct service staff but the Monitor found no such documentation.<br><br>Similar improvement was noted in the Action Plans developed by the Facility. The plans reflected both detail and a logical progression through tasks. The majority of the Action Plans, however, emphasized procedural and quantitative goals rather than qualitative improvements.<br><br>Overall, despite the limitations noted, it was evident that the Facility had implemented meaningful and substantive changes to both the Self-Assessment and Action Plans. |
| | **Summary of Monitor's Assessment:**<br>Observations, interviews, and record reviews were conducted on-site at RGSC from 8/27/2012 through 8/31/2012. Record reviews continued off-site for several days following the site visit. Based upon the information gathered, it was determined that only one Provision, K.2, was in substantial compliance with the Settlement Agreement.<br><br>Although there were no other Provisions found to be in Substantial Compliance, it was evident that RGSC had achieved meaningful progress in several areas related to Section K of the Settlement Agreement. These improvements included the following.<br>• The hiring of a BCBA,<br>• The enhancement of both internal and external peer review,<br>• An increase in the number of individuals for whom psychological evaluations were provided,<br>• An increase in the completion of intellectual and adaptive assessments,<br>• Substantially enhanced PBSP data graphs, and<br>• Improvements in the quality of SFAs and PBSPs.<br><br>It must be noted that in many of the areas of improvement, the new procedures had only recently been implemented. As a result, only a very small sample was available for review. Determination regarding substantial compliance within these Provisions will require additional review during the next site visit.<br><br>Despite areas of improvement, there were provisions where either minimal progress had been achieved or evidence supporting improvements was not provided. For example, psychiatric staff had reported significantly enhanced integration with Facility psychologists. A review of psychological evaluations, SFAs, and PBSPs, however did not reflect this integration. At best, the SFA or PBSP might present psychotropic medications and targets, but no evidence was presented of attempts to identify the behavioral correlates of diagnosed mental illness or an inclusion of those targets in the SFA process. |

| | |
|---|---|
| | An additional area of substantial concern involved the failure of the Facility to ensure that documentation required for Human Rights review was submitted in a timely manner. Since the previous site visit, Rights Violations (the term used by the Facility) due to delays in paperwork submissions had been above 10 per month for five of the past six months. During August 2012, the month of the site visit, a total of 26 Rights Violations were documented.<br><br>In addition to Human Rights Committee issues, substantial delays were also noted in the implementation of behavioral interventions. During the six months prior to the current site visit, the delay between PBSP development and implementation averaged slightly over 74 days.<br><br>Improvements in assessments and interventions reflected positive growth. The benefits of those improvements, however, require timely review and implementation. |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>K1</td><td>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.</td><td><u>Historical Perspective</u><br>During the baseline site visit, RGSC employed no Behavior Services staff who were certified as a behavior analyst. Between the baseline visit and August 2011, 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). Shortly thereafter, Ms. Gianotti left employment with RGSC. At the time of the March 2012 site visit Vanessa Villarreal, M.Ed., who was serving as interim Chief Psychologist, was enrolled in coursework required for obtaining Board Certification.<br><br><u>Current Site Visit</u><br>At the time of the current site visit, RGSC had just hired Ruben Nieto as Psychology Director. Mr. Nieto was Board Certified as a behavior analyst. It was unclear whether Ms. Villareal intended to further pursue Board Certification.<br><br>
<table>
<tr><td></td><td>3/2010</td><td>3/2012</td><td>8/2012</td></tr>
<tr><td>Percent of staff who were BCBAs</td><td>0%</td><td>0%</td><td>50%</td></tr>
<tr><td>Percent of staff lacking BCBA who were pursuing board certification</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>
In addition, the Facility had contracted with one BCBA to write PBSPs.<br><br>Based upon the documentation obtained during the current site visit, the Facility was not in substantial compliance with the Provision.</td><td>Noncompliance</td></tr>
</table>

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| 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, RGSC employed a full-time director of Behavioral Services--Ruben Nieto. Mr. Nieto was extensively experienced in the field of intellectual and developmental disabilities, was a board certified as a behavior analyst. Based upon her credentials and demonstrated competence, the employment of Mr. Nieto by RGSC satisfied this Provision of the Settlement Agreement. | Substantial Compliance |
| K3 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs. | The role of the peer review committee has been briefly defined in the professional literature as follows.<br>*"In cases in which withholding or implementing treatment involves potential risk, Peer Review Committees and Human Rights Committees play distinct roles in protecting client welfare. Peer Review Committees, comprised of experts in behavior analysis, impose professional standards to determine the clinical propriety of treatment programs." (The Right to Effective Behavioral Treatment. Van Houten, R. et.al. 1988. Journal of Applied Behavior Analysis, 21, 381-384.*<br><br>In order to meet these goals, an organization or Facility must ensure that the necessary resources are available, policies and procedures are implemented, and demonstrably competent staff participates. In addition, steps must be taken to ensure that the implementation of peer review does result in interventions that adhere to acceptable practices.<br><br><u>Historical Perspective</u><br>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, including a committee lacking expertise in applied behavior analysis, the failure to make use of clinical indicators in formulating treatment decisions, and a lack of integration between psychology and medical services.<br><br>During the August 2010 site visit, it was noted that 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. | Noncompliance |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>At the time of the March 2012 site visit the internal peer review process had been revised again in October 2011. This revision provided additional psychology staff as members of the peer review committee, and included Cheryl Fielding, PhD, BCBA, as Chair. Dr. Fielding was providing these services under contract at RGSC.<br><br><u>Current Site Visit</u><br>During the current site visit, it was noted that the Facility had implemented a revised peer review process in June 2012 that included both internal and external peer review, and a rubric for reviewing behavior assessment and interventions. As only six Structural/Functional Assessments (SFAs) and PBSPs had been approved by the peer review process at the time of the current site visit, the ability to assess the peer review process was limited. Furthermore, the Facility indicated that additional changes were pending in relation to the structure of the internal peer review committee, the provider of external peer review, and the rubric used to review the SFAs and PBSPs.<br><br>Due to the recent and pending changes, it was not possible to determine compliance with the Settlement Agreement.</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><u>Historical Perspective</u><br>During previous site visits at RGSC, observations and record reviews had revealed a diverse use of data collection strategies. During the March 2012 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.<br><br><u>Current Site Visit</u><br>Information obtained from record reviews and observations during the current site visit reflected only modest improvement. For a sample, the Facility was asked to provide all PBSPs that had been completed in the past six months using the new PBSP format. The Facility provided six PBSPs that met the stated criteria, with only four of the six submitted PBSPs including data graphs. The table below includes information obtained from the sample of six records.
<table>
<tr><th></th><th>3/2010</th><th>3/2012</th><th>8/2012</th></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress</td><td>0%</td><td>36%</td><td>0%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress</td><td>0%</td><td>0%</td><td>17%</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>67%</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

| # | Provision | Assessment of Status | | | | Compliance |
|---|---|---|---|---|---|---|
| | | Targeted behaviors graphed sufficient for decision-making | 0% | 45% | 67% | |
| | | Replacement behaviors graphed sufficient for decision-making | 0% | 0% | 0% | |
| | | Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level | 0 % | 100% | 67% | |
| | | 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% | 50% | |
| | | Criteria for revision are included in the PBSP | 0% | 18% | 67% | |
| | | Progress evident, or program modified in timely manner (3 Months) | 0% | 55% | 33% | |

Due to the small sample size, as well as a lack of data graphs for some submissions, it was not possible to identify clear trends in data collection and treatment monitoring. The evidence did suggest, however, that the Facility was improving in some areas. There were additional indications, however, that the Facility had deteriorated in other areas.

Areas of suggested improvement included the following.

- For the four out of six PBSPs (67%) where data graphs and progress notes were submitted, treatment targets were individually analyzed for treatment response.
- For the four out of six PBSPs (67%) where data graphs and progress notes were submitted, data graphs were sufficient for decision making. Despite the noted sophistication of the data graphs, however, the data were of questionable validity and reliability
- For three out of six PBSPs (50%), data graphs indicated that changes in the PBSPs or other interventions had been initiated in response to data trends.
- For four out of six PBSPs (67%), the PBSP included specific success and failure criteria.

Areas of suggested deterioration in performance included the following.

- For none out of six PBSPs (0%) was data collection sufficient to determine progress. For all PBSPs, the specified data collection procedures for undesired behavior allowed data recording to be delayed until the end of the staff person's shift. In addition, there were numerous statements that data collection forms for replacement behaviors were either returned blank or not returned at all. During the previous site visit, data collection was identified as sufficient for 36% of the

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>sample.<br>• Due to the Facility providing data graphs and progress notes for only four of six PBSPs (67%), it was not possible to determine that all PBSPs were reviewed monthly. During the previous site visit, 100% of PBSPs in the sample were reviewed monthly.<br><br>Based upon the information obtained during the site visit, it was evident that data collection, presentation, and use at RGSC remained inadequate. Although some improvement was noted, none of the individual areas reflected the degree of success necessary for a determination of substantial compliance.</td><td></td></tr>
<tr><td>K5</td><td>Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.</td><td><u>Intellectual and Adaptive Behavior Assessment</u><br>Intellectual and adaptive behavior testing results play an integral role in understanding an individual. While a functional assessment may provide vital information regarding a single behavior or functional class of behaviors, intellectual and adaptive behavior testing can prove useful in the development of teaching programs. To be useful, however, it is important that the tests be relatively recent, within one year for adaptive behavior testing and five years for intellectual testing. In addition, interpretation of the results of the tests must go beyond the reporting of scores and elaborate upon specific abilities and limitations, as well as how those abilities and limitations are manifested in the person's daily activities.<br><br><u>Historical Perspective</u><br>At the time of the baseline visit, no individuals living at RGSC had been provided with a psychological evaluation.<br><br><u>Current Site Visit</u><br>At the time of the current site visit, an initial sample of 10 records was selected to assess the psychological evaluations. If this initial sample had suggested substantial compliance, a second much larger sample would have been collected. As the results from the initial sample did not suggest substantial compliance, as reflected in the table below, no second sample was selected.<br><br><table><tr><td></td><td>3/2010</td><td>3/2012</td><td>8/2012</td></tr><tr><td>A Psychological Assessment had been completed.</td><td>0%</td><td>0%</td><td>100%</td></tr><tr><td>The Psychological Assessment was less than one year old</td><td>0%</td><td>0%</td><td>100%</td></tr><tr><td>The Psychological Assessments contained</td><td>0%</td><td>0%</td><td>20%</td></tr></table></td><td>Noncompliance</td></tr>
</table>

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|

| | | | |
|---|---|---|---|
| findings from an intellectual test administered within the previous five years. | | | |
| The Psychological Assessments contained findings of adaptive behavior assessment conducted within one year prior to the date of the Psychological Assessment. | 0% | 0% | 40% |

It was evident from the initial sample and other documentation that all individuals living at RGSC had been provided with a psychological evaluation report within the past year. The contents of those psychological evaluation reports, however, were able to corroborate that only two of the 10 individuals (20%) had been provided an intellectual assessment within the past five years and that only four of the 10 individuals (40%) had been provided with an adaptive behavior assessment within one year prior to the Psychological Assessment. In some reports, assessment dates clearly reflected that the assessments occurred beyond the maximum time frames. In other circumstances, however, assessments were indicated to have occurred but no specific dates were provided for those assessments

In addition to providing intellectual and adaptive behavior assessments, it is crucial that the findings of those assessments be presented in a manner that goes beyond the reiteration of scores and facilitates the identification of personal strengths and limitations. A sample of 10 records was selected to determine the degree to which this was achieved.

| | 3/2010 | 3/2012 | 8/2012 |
|---|---|---|---|
| Psychological Assessments included a narrative summary of how the results from intellectual assessments would facilitate the understanding of the individual's strengths and needs. | 0% | 0% | 0% |
| Psychological Assessments included a narrative summary of how the results from adaptive behavior assessments current or otherwise would facilitate the understanding of the individual's strengths and needs. | 0% | 0% | 0% |

Based upon information compiled during the current site visit, RGSC had been unable to ensure the psychological evaluations included current adaptive behavior and intellectual assessments. Furthermore, where current assessments existed, the Facility had not presented the findings of those assessments in a manner that facilitated the development

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
of skill acquisition programs or contributed to the understanding of the person's strengths and needs.<br><br>
<u>Behavior Assessment</u><br>
<u>Historical Perspective</u><br>
At the time of the baseline visit, and continued through the site visits in 2011, RGSC had not provided adequate SFAs for the majority of individuals requiring behavior assessment. In March of 2012, the Facility demonstrated notable improvement in the available SFAs. Due to personnel issues at the time of the March 2012 site visit, it was not evident that RGSC would be able to maintain the progress achieved.<br><br>
<u>Current Site Visit</u><br>
At the time of the current site visit, a new procedure and format for SFAs had been recently implemented. Due to the recent implementation of these new practices, only six SFAs were available for inclusion in the SFA sample. The status of these SFAs is included in the table below.
<table>
<tr><th></th><th>3/2010</th><th>3/2012</th><th>8/2012</th></tr>
<tr><td>Assessment or review of biological, physical, and medical status</td><td>0%</td><td>91%</td><td>100%</td></tr>
<tr><td>Review of personal history</td><td>0%</td><td>73%</td><td>100%</td></tr>
<tr><td>A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis</td><td>0%</td><td>82%</td><td>0%</td></tr>
<tr><td>The process or tool utilizes both direct and indirect measures</td><td>0%</td><td>82%</td><td>0%</td></tr>
<tr><td>Identification of setting events and motivating operations relevant to the undesired behavior</td><td>0%</td><td>64%</td><td>100%</td></tr>
<tr><td>Identification of antecedents relevant to the undesired behavior</td><td>0%</td><td>64%</td><td>100%</td></tr>
<tr><td>Identification of consequences relevant to the undesired behavior</td><td>0%</td><td>64%</td><td>100%</td></tr>
<tr><td>Identification of functions relevant to the undesired behavior</td><td>0%</td><td>64%</td><td>100%</td></tr>
<tr><td>Summary statement identifying the variable or variables maintaining the target behavior</td><td>0%</td><td>64%</td><td>100%</td></tr>
<tr><td>Identification of functionally</td><td>0%</td><td>64%</td><td>100%</td></tr>
</table>
</td><td></td></tr>
</table>

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|

| | | | |
|---|---|---|---|
| equivalent replacement behaviors relevant to the undesired behavior | | | |
| Identification of preferences and reinforcers | 0% | 0% | 100% |

Based upon the SFAs available for review, it was suggested that the new SFA format and procedures comprised a substantial improvement over previous assessments. The majority of elements for the relevant Provisions reflected 100% compliance with expectations. Two important elements, however, reflected ratings of 0% success. For these two elements, the weaknesses for the most part involved a failure to provide details about procedures, outcome measures, respondents and dates, rather than the lack of any assessment.

In most circumstances, indications of such high levels of success would result in the selection of a second, larger sample for review. In this particular situation, however, no additional SFAs had been completed using the new format. Therefore, a more comprehensive review was scheduled for the March 2013 site visit.

One area of continued weakness was noted in relation to the SFA. The review of six SFAs revealed only minimal attention was directed toward integrating environmentally-based behavior and the symptoms of mental illness into the assessment process.

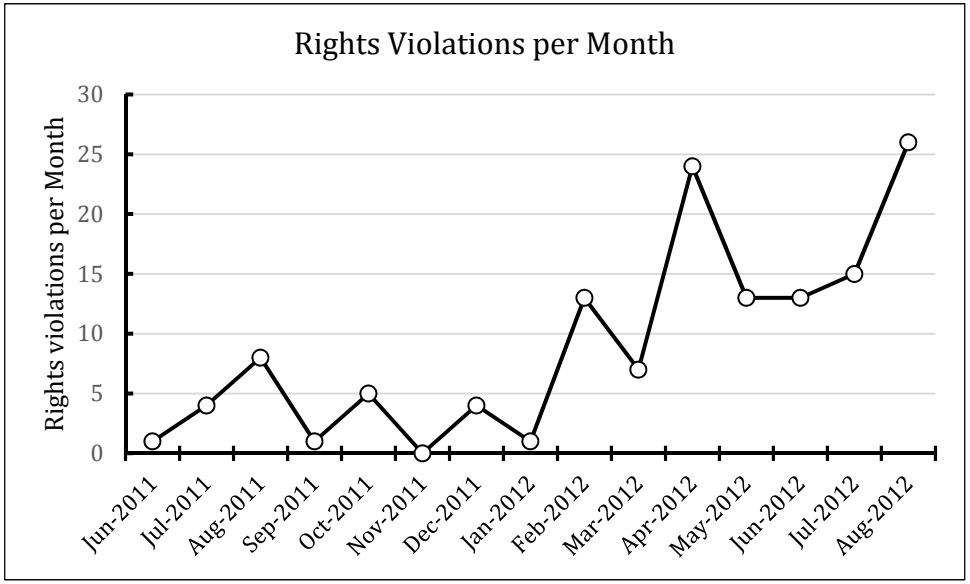
| | 3/2010 | 3/2012 | 8/2012 |
|---|---|---|---|
| Screening for psychopathology, emotional, and behavioral issues | 0% | 18% | 100% |
| Differentiation between learned and biologically based behaviors. | 0% | 9% | 0% |
| Identification of behavioral indices of psychopathology | 0% | 0% | 50% |
| Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities | 0% | 0% | 0% |

All six of the reviewed SFAs included some process for reviewing potential symptoms of mental illness. The processes utilized most often, however, reflected a review of behavior and a mental status exam; no formal assessments using instruments designed specifically for people with intellectual disabilities were included. None of the SFAs included a differentiation between learned behaviors and symptoms of mental illness, and only three of the six SFAs identified behavioral indices of mental illness diagnoses. Due to the limitations noted, the ability of the reviewed SFAs to facilitate successful and relevant

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | PBSPs was substantially limited.<br><br>Overall, information obtained from observations and documentation during the site visit reflected a mixture of progress and continued weaknesses. For some issues, such as the use of acceptable functional assessment procedures, weakness could be addressed through an increased detail in the documentation of assessment procedures. For other issues, especially the integration of assessments and interventions for mental illness and learned behaviors, the noted limitations reflected the need for much more comprehensive approaches to the assessment process. | |
| K6 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data. | Based upon the information presented in K5, documentation in the record continued to reflect that psychological assessments were not based upon complete clinical and behavioral data. | Noncompliance |
| K7 | Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures. | Records reflected that individuals newly admitted to the Facility had a psychological assessment completed within 30 days of admission. Records did not reflect that individuals admitted to the Facility always received an intellectual or adaptive behavior assessment at the time of admission regardless of the amount of time since the most recent assessment. The same was true for individuals already living at the Facility: Although each individual had a Psychological Assessment report completed in the past 12 months, those reports did not consistently include current intellectual and adaptive skill test results. For example, in the 10 Psychological Assessment reports included in the current sample, only two (20%) included an intellectual test completed within five years prior to the report and only four (40%) had been provided with adaptive skill testing within the 12 months prior to the report. In some reports, testing dates clearly reflected that the tests were administered beyond the maximum time frames. In other circumstances, however, testing was indicated to have occurred but no specific dates were provided for those tests.<br><br>Documentation obtained during the current site visit also reflected that psychological evaluations had been completed at least annually for all individuals. In most cases this reflected as often as needed. As this was the first year that most individuals had received a psychological evaluation, the measure was not reflective of how well the Facility could ensure that psychological evaluations would be provided as often as needed on a routine basis. | Noncompliance |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>3/2010</td><td>2/2012</td><td>8/2012</td></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>100%</td></tr>
<tr><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>89%</td><td>100%</td><td>100%</td></tr>
<tr><td>Psychological Assessments that included intellectual testing completed within the five years prior to the psychological assessment</td><td>0%</td><td>0%</td><td>20%</td></tr>
<tr><td>The Psychological Assessments contained findings of adaptive behavior assessment conducted within one year prior to the date of the Psychological Assessment.</td><td>0%</td><td>0%</td><td>40%</td></tr>
</table>
</td><td></td></tr>
<tr><td>K8</td><td>By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that 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</td><td>Informed consent requires that the consenter be provided with sufficient information about the proposed intervention to formulate a decision about whether or not to grant consent. In most situations, the consenter must be provided with the following information.<ul><li>Implications of going without treatment and of treatment being postponed for different periods</li><li>The range of accessible diagnostic or treatment options</li><li>The benefits each option offers</li><li>The possibilities of diagnostic false results or treatment failures</li><li>The risks and discomforts of diagnostic or treatment options even when successful</li><li>Short-term injuries that diagnostic or treatment failures may cause</li></ul></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>interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.</td><td>
<ul><li>Long-term effects of diagnostic or treatment options, favorable and unfavorable, separating probabilities from possibilities</li></ul>
It is the responsibility of the Facility to conduct the assessments essential for informed consent. The evidence of continued weaknesses in the SFA process, as well as difficulties noted in the treatment monitoring process, indicated that RGSC had not achieved success in meeting the obligation of providing sufficient information to the consenter. As a result, the Facility frequently failed to obtain valid and informed consent.<br><br>
<u>Historical Perspective</u><br>
At the time of the baseline visit, 78% of individuals sampled were provided with adequate consents. By March 2012, this had dropped to 36% of individuals sampled. Problems noted during the March 2012 site visited included consents that had expired and a lack of consents in the individuals' records.<br><br>
<u>Current Site Visit</u><br>
Of the six individuals included in the current sample, the submitted records for five individuals included a signed consent form. Each of these "consent forms", however, included only generic statements indicating that neither psychiatric nor behavior services represented an exact science and that no outcome could be guaranteed. There was no indication on the form as to what the representative was consenting. Furthermore, there was nothing to indicate that the five PBSPs for which consent was obtained differed substantially from the sixth PBSP for which no consent was documented. Based upon the provided information, although consents forms were in 80% of records, there was little to suggest that actual consent for any procedures had been sought or obtained by the Facility.
<table>
<tr><td></td><td>3/2010</td><td>3/2012</td><td>8/2012</td></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>0%</td></tr>
</table>
In addition to the issues with the consents and approvals for the individuals in the sample, there were also indications of numerous rights violations (the term used by the Facility) associated with the Human Rights Committee review process. At the time of the March 2012 site visit, RGSC had documented 20 occurrences over the previous six months in which individuals could not be reviewed due to a failure of the QDDP to submit the necessary paperwork in a timely manner. At the time of the current site visit, rights violations had demonstrated more than a 400% increase to 98 violations during the previous six months. As identified during the previous site visit, the majority of
</td><td></td></tr>
</table>

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | violations identified during the current site visit reflected a failure by QDDPs and/or Human Rights Committee members to complete and submit the necessary forms and documentation.<br><br>  <br><br><br>Based upon information relating to consents and Human Rights Committee-related rights violations, it was evident that RGSC was experiencing increasing difficulty in ensuring adequate protections for the individuals living at the Facility. A review of available documentation, as well as observations of the Human Rights Committee, strongly suggested that a substantial factor contributing to the failure to ensure adequate protections was a failure by the individuals tasked with providing the necessary documentation to actually provide the required documentation. In addition to inhibiting the ability of the Facility to ensure adequate protections, the increasing number of risk violations contributed to delays in the delivery of necessary services.<br><br>The lack of timely implementation was a substantial problem noted in PBSPs. The Facility provided tracking information on only five of the six PBSPs included in the sample. This information, however, reflected substantial delays in PBSP implementation.<br><br>Average delay between PBSP development and implementation \| Average delay between obtaining consent and implementation \| Percentage of delay attributable to post-consent procedures | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|

| 76.4 Days | 60.2 Days | 79% |
|---|---|---|

It is always of importance to ensure that programs are implemented as quickly as is prudent to ensure that individuals receive the services essential to their well-being. When the program involves a formal behavior intervention to address an identified need, timely implementation is essential. In many circumstances, undesired behavior imposes substantial limitations on a person's independence and has the potential to present risk of physical harm to the person or others around them. Documentation provided by RGSC demonstrated a consistent pattern of substantial delays in providing individuals with essential services.

At the time of the current site visit, a new procedure and format for SFAs had been recently implemented. Due to the recent implementation of these new practices, only six SFAs were available for inclusion in the SFA sample. The findings from the review are presented in the table below.

| | 3/2010 | 3/2012 | 8/2012 |
|---|---|---|---|
| Rationale for selection of the proposed intervention. | 0% | 73% | 100% |
| History of prior intervention strategies and outcomes. | 0% | 36% | 100% |
| Consideration of medical, psychiatric and healthcare issues. | 0% | 9% | 100% |
| Operational definitions of target behaviors. | 0% | 55% | 100% |
| Operational definitions of replacement behaviors. | 0% | 73% | 100% |
| Description of potential function(s) of behavior. | 0% | 55% | 100% |
| Use of positive reinforcement sufficient for strengthening desired behavior | 0% | 18% | 67% |
| Strategies addressing setting event and motivating operation issues. | 0% | 64% | 100% |
| Strategies addressing antecedent issues. | 0% | 64% | 100% |
| Strategies that include the teaching of desired replacement behaviors. | 0% | 91% | 100% |
| Strategies to weaken undesired behavior. | 0% | 27% | 100% |
| Description of data collection procedures. | 0% | 36% | 0% |
| Baseline or comparison data. | 0% | 91% | 83% |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Treatment expectations and timeframes written in objective, observable, and measureable terms.</td><td>0%</td><td>36%</td><td>100%</td></tr>
<tr><td>Clear, simple, precise interventions for responding to the behavior when it occurs.</td><td>0%</td><td>0%</td><td>100%</td></tr>
<tr><td>Plan, or considerations, to reduce intensity of intervention, if applicable.</td><td>0%</td><td>0%</td><td>100%</td></tr>
<tr><td>Signature of individual responsible for developing the PBSP.</td><td>0%</td><td>91%</td><td>100%</td></tr>
</table>
<br>Based upon the information obtained from the sample, RGSC had demonstrated progress across most Provisions related to PBSP content in comparison with the original baseline visit, as well as the March 2012 site visit. Caution is warranted, however, when drawing conclusions from this sample. As indicated, new forms and procedural changes had only recently been implemented. This limited the review to only six records. Further review will be necessary during the next site visit in March of 2013.
</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.<br><br>Specific information about the quality of behavior data was unavailable, as measures of interobserver agreement (IOA) were not consistently implemented at the Facility. Records reflected that IOA data had been collected for a small number of individuals in February through May 2012. IOA data collection had been stopped at that point and a new IOA data collection system was not implemented until shortly before the current site visit. This lack of consistent reliability measures reflected that the Facility had made only slight progress since the baseline site visit. As reliability data were not consistently collected, data graphs did not consistently 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>
<br>Of the six PBSPs included in the site visit sample, the Facility provided data graphs and Progress Notes for only four of the PBSPs. This lack of supporting documentation dropped the ratings for all elements other than IOA and data integrity to 67%.
</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>3/2010</th><th>3/2012</th><th>8/2012</th></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>0%</td><td>36%</td><td>67%</td></tr>
<tr><td>Horizontal axis and label</td><td>0%</td><td>100%</td><td>67%</td></tr>
<tr><td>Vertical axis and label</td><td>0%</td><td>91%</td><td>67%</td></tr>
<tr><td>Condition change lines</td><td>0%</td><td>100%</td><td>67%</td></tr>
<tr><td>Condition labels</td><td>0%</td><td>100%</td><td>67%</td></tr>
<tr><td>Data points and path</td><td>0%</td><td>100%</td><td>67%</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>67%</td></tr>
</table>
<br>Other than the issues related to IOA and data integrity, the four sets of data graphs and progress notes were very thorough, included abundant treatment information, and reflected sophisticated data graphs. Due to the very limited sample provided by the Facility, additional review will be required during the March 2013 site visit.
</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>One element of ensuring that PBSPs can be understood and implemented by staff is writing in a style that is concise, clearly organized, and makes use of simple language. Writing style can be assessed and quantified using the Flesch-Kincaid Grade Levels. Microsoft Word 2010 includes an option to establish the grade level of a selection of text using the Flesch-Kincaid Grade Levels.<br><br>During the March 2012 site visit, documentation provided by RGSC reflected that the staff instructions portion of all PBSPs was within the 9th to 10th grade reading level. During the current site visit, the Monitor utilized Microsoft Word 2010 to calculate readability and found documentation reflected that 80% of staff instructions for PBSPs were rated below the 12th grade level, and the average grade reading level for those instructions was grade 11.9.<br><br>Based upon this information alone, it appeared that PBSPs at RGSC had become less rather than more readable. It should be noted, however, that the readability data provided by the Facility reflected all PBSPs. Of those few PBSPs completed in the new format, although readability data were unavailable, the language and writing style used suggested that the staff instructions from those PBSPs were much easier to read and comprehend.<br><br>As indicated above, readability statistics are only one element of ensuring that PBSPs can be understood and implemented by staff. Additional elements require that the Facility implement a system to monitor and ensure treatment integrity during which staff are</td><td>Noncompliance</td></tr>
</table>

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | able to explain how they implement the individual's PBSP. At the time of the site visit, RGSC had no on-going system for assessing or monitoring treatment integrity.<br><br>Based upon available information, RGSC was monitoring only the portion of this Provision related to language and writing style. Despite this monitoring, PBSPs were trending toward more complex instructions. Documentation did not reflect any additional efforts to ensure that staff were able to understand and implement PBSPs. As a result, the Facility had not achieved substantial compliance. | |
| K12 | Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans. | Documentation provided by RGSC reflected no competency-based training for staff had been implemented. | Noncompliance |
| 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 one staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 70 individuals residing at the Facility and fell short of the required ratio of one BCBA for every 30 individuals. If all staff positions eligible for BCBA credentialing were filled by a BCBA, the Facility would have one BCBA for every 35 individuals residing at the facility.<br><br>RGSC currently employs 2 Psychological Assistants. This would be sufficient to meet the ratio of one assistant for every two BCBAs even if all qualifying positions were staffed by a BCBA. | Noncompliance |

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

1. 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 is encouraged to develop and implement and comprehensive system of data collection that ensures the timely recording of behavior. This system should include behaviors targeted for increase and 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)
3. 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 observable correlates of symptoms of mental illness. (Provision K5)

4. RGSC needs to be more diligent in the provision of intellectual and adaptive behavior testing, and ensure that test findings are incorporated into the ISP process. (Provision K5)
5. Although no individuals were provided psychological services other than PBSPs at the time of the site visit, the Facility needs to begin to identify what other psychological services may benefit individuals and be prepared for when the need does arise. It is recommended that RGSC develop a system to ensure that non-PBSP services reflect an evidence-based approach to intervention and include means to ensure integration with PBSPs and other services and supports. (Provision K8)
6. RGSC should develop and implement a system to ensure that rights violations (the term used by the Facility), especially those due to failure to submit paperwork in a timely manner, are prevented. (Provision K9)
7. The Facility should develop and implement a system that ensures that PBSPs include all necessary elements prior to those PBSPs being implemented. (Provisions K3 and K9)
8. RGSC should develop a process to ensure that PBSPs can be easily read and implemented by staff. (Provision K11)

The following are offered as additional suggestions to the Facility:

1. RGSC should ensure that all staff participate in a competency-based process for developing skills in general applied behavior analysis, as well as the implementation of specific interventions. (Provision K12)

| SECTION L: Medical Care | |
|---|---|
| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. RGSC Self-Assessment 8/13/12<br>2. RGSC Action Plan 8/9/12<br>3. RGSC Medical Services, Standard Operating Procedure, ICF-MR 400-14 Medical Care, dated December 9, 2010<br>4. RGSC Sentinel Events, Standard Operating Procedure FW 108-13, Date Reviewed/Revised: March 2012, including Root Cause Analysis and Action Plan in Response to a Sentinel Event, RCA #12, Blank Form<br>5. RGSC Confidentiality Guidelines for Participants in Peer Review Committee for Sentinel Events, including Signed Signature Sheets of Participants Related to the Death of Individual #54<br>6. Clinical Death Review Completed by an External Physician, No Date<br>7. RGSC Clinical Death Review Committee and Administrative Death Review Committee Minutes, 6/6/2012<br>8. State of Texas Certificate of Death for Individual #54, 5/2/2012<br>9. Cameron County Forensic Pathology Report for Individual #54, 4/24/2012<br>10. RGSC Quality Improvement Death Review of Nursing Services for #54, 5/30/2012<br>11. RGSC Medication Administration Record for Individual #54, 4/17/2012 through 4/24/2012<br>12. RGSC Medication/Treatment/Diet Record for Individual #54, April 2012<br>13. RGSC Report of the Death of a Person Served for Individual #54, 4/17/2012<br>14. RGSC Timeline Report Leading up to Individual #54's Death, 2/13/2012 through 4/17/2012<br>15. RGSC Discovery of Injury Preliminary Investigation, Nursing Referral, 4/16/2012<br>16. RGSC Unusual Incident Report, URI12-41813988, 4/17/2012<br>17. RGSC Corrective Action Plan Guidelines<br>18. RGSC Plan of Action Related to Death Review Recommendations, No Date<br>19. RGSC Action/Corrective Action Reporting Documents and Signed Training Rosters<br>20. RGSC Clinical Indicator: Bowel Obstruction Report, 7/5/2012<br>21. RGSC Bowel Management (Constipation and Bowel Obstruction) Training Materials Presented at the Medical Executive Meeting, 7/18/2012<br>22. RGSC Client Work Station (CWS) Nursing Integrated Progress Notes, 4/13/2012 through 4/17/2012<br>23. RGSC Nursing Events Daily Logs, 4/12/2012 through 4/17/2012<br>24. Physician Board Certification documents<br>25. List of CME events attended by physicians<br>26. Medical Internal and External Audit Reports for Round Five<br>27. CPR certificates for primary care physicians<br>28. Most recently completed Individual Support Plans (ISP) for ten individuals randomly selected by the Facility: #150, #76, #27, #12, #62, #2, #82, #3, #66, #33<br>29. List of all fractures that occurred during the past six months and associated physician notes, consultations, IDT reports, x-rays, and hospital records.<br>30. Active clinical records for Individuals #19, #86, #35, #79, #40, ##5, #126, #101, #113, #97, #29, #96, #51, #23, #47, #11, #66, #82, and #44 |

| | |
|---|---|
| | 31. Integrated Progress Notes for Individuals #115, #4, #63, #91, #44, #126, #69, #3, 75, and #113<br>32. Annual medical assessments for Individuals #5, #126, #101, #113, #97, #79, #29, #96, #51, #47, #66, #82, #44, #116, #23, #24, #11, #46, #26, and #15<br>33. Bone density results, past 12 months labs, and ISPs for individuals #116, #23, #24, #11, #46, #26, and #15<br>34. List of all individuals over the age of 50, and who had and did not have screening colonoscopy, and the reason why they did not have a screening colonoscopy if one was not completed<br>35. List of all women over the age of 40 who had a screening mammogram, and a list and the reason why they did not complete a mammogram, if a screening mammogram was not obtained<br>36. For the past ten emergency room (ER) visits, copies of all associated IPNs written by the Facility primary care physician, ER reports, and all follow-up orders written by the primary care provider<br>37. List of all individuals diagnosed with seizure disorder, date of last neurology consultation, and list of their antiepileptic drugs (AED)<br>38. List of all individuals with an implanted vagal nerve stimulator (VNS)<br>39. List of Individuals with known hypertension and copy of their most recent annual medical assessment, cardiology consultation reports, blood pressure flow sheet, past 12 months labs, EKGs, and current medication list<br>**People Interviewed:**<br>1. Dr. John Partin, MD. Primary Care Provider<br>2. Dr. David Moron, MD. Medical Director<br>3. Dr. Brian O'Donnell, MD. Primary Care Provider<br>4. Lorraine Hinrichs, ICF-DD Program Director<br>5. Mary Ramos, Quality Management Director<br>6. Yolanda S. Gonzalez, RN, Chief Nurse Executive (CNE)<br>7. Michael Robinson, RN, Quality Assurance Nurse (QA)<br>**Meeting Attended/Observations:**<br>1. Individuals #40, #86, #96, #46, #15, #35, #79, #19, #116, #23 were observed at their homes. Individuals #19, #79, and #35 were also observed at their day program.<br>2. Medical Morning Meeting |
| | **Facility Self-Assessment:**<br>The Facility reported noncompliance with Provisions L1 through L4, of the Settlement Agreement, and the Monitoring Team concurs with this assessment. The Monitoring Team does not agree with the Facility's plan of improvement or indicators used to assess compliance. The Facility is relying on result of the internal and external medical audits to determine compliance with Provision L1 through L4; however, the Monitoring Team determined that the medical audit process did not provide insight into the clinical performance of physicians, and did not enable an adequate understanding of how the Facility assesses whether requirements of provisions for clinical practice, or clinical outcomes are met. For example, the self-assessment does not identify how core clinical indicators are used to assess quality of medical care, how timely preventive and emergency care are provided, whether clinical care provision meets the requirements of the Health Care Guidelines or current generally accepted practice, or whether policies are adequate to meet the requirements of the Settlement Agreement and are implemented accurately. For |

| | |
|---|---|
| | example, the self-assessment for Provision L3 addresses only an internal medical provider review and not collection and analysis of data relating to the quality of medical services.<br><br>The Facility also provided a plan that identified actions the Facility plans to take to achieve compliance. Some actions are very clear and specific, such as "Audit 5 charts per month to ensure annual history and physical…completed," whereas others are very general and do not provide any detail of the process to be used, such as "Use external medical provider audit to improve quality of medical provider services." The actions for Provision L.3 are clear and sequential in regard to the internal medical provider review but do not address collecting data and analyzing data for trends. |
| | **Summary of Monitor's Assessment:**<br>The Monitoring Team noted significant and continued improvement with the provision of medical services at the Facility. For example, the physical examinations conducted for annual medical assessments and acute care conditions were more comprehensive; assessment of acute medical conditions was occurring more proactively and promptly, consultations were being provided more assertively; and the overall management of seizure disorder meets or exceeds standard of care practice. In general, the Monitoring Team is complimentary to the Facility leadership, staff, and in particular, the medical staff, for their impressive work in moving the Facility closer to substantial compliance. The Monitoring Team did note areas that continue to need improvement, as outlined below:<br><br>**Provision L1:** The Monitoring Team agrees with the Facility's self-assessment of noncompliance with Provision L1, because clinical practice continues to fall outside of standard of care practice. Some examples that will help the Facility gain compliance include making sure that all identified clinical conditions are listed as an actual diagnosis; ensure that action plans are delineated for each diagnosis, and are comprehensive; and ensure that all chronic care issues are addressed either at a quarterly medical assessment, or as recommended by relevant professional organizations. Although not all medical conditions were evaluated at this review by the Monitoring Team, the Monitoring Team expects that medical conditions, especially those that commonly occur in individuals with developmental disabilities, such as neuromotor and musculoskeletal disorders, chronic constipation, pneumonia, urinary track infections, and syndromal conditions are assertively managed. The Monitoring Team is concerned that the Facility had yet to develop a meaningful process to manage clinical database elements, and notes that compliance with Provision L will require a comprehensive, and meaningful process that enables prompt assessment, and updating of database elements. Most important, the Monitoring Team noted significant and serious deficiencies with regards to monitoring and following up on individuals who were at risk for bowel impaction and obstruction, and it is essential that policies, and practices are developed that will ensure appropriate monitoring and follow-up occurs.<br><br>**Provision L2:** Because the Facility had yet to fully implement a process that enabled an assessment of the primary care physician clinical performance, and because of an ineffective mortality review process, that did not identify important system issues related to a recent death at the Facility, and did not have appropriate policies and procedures for conducting mortality reviews, the Monitoring Team determined that the Facility remains not in compliance with Provision L2. As noted in this report, the Facility must |

| | |
|---|---|
| | address important system issues that were identified by the Monitoring Team, with regards to its recent death.<br><br>**Provision L3:** Because the Facility did not have a process in place that would enable s systems review of clinical outcomes, the Monitoring Team concurs with the Facility and determined that it remains noncompliant with Provision L3, of the SA.<br><br>**Provision L4:** The Monitoring Team concurs with the Facility's self-assessment of noncompliance because it did not have effective policies and procedures to help ensure that the provision of medical services meets or exceeds standard of care practice. The Facility must review its clinical processes, and develop and implement meaningful medical policies. |

| # | 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. | Provision L1 is a broad section that assesses the Facility's ability to provide medical care to individuals served by the Facility. To assess Provision L1, the Monitoring Team reviewed the Facility's medical administration, integration of medical services into the interdisciplinary team (IDT) process delivery of routine medical care, access to medical specialists, provision of preventive health services, emergency room utilization, and the management of acute and chronic medical conditions.<br><br><u>Medical Administration</u><br>To assess medical administration the Monitoring Team reviewed physician staffing, certification status, recent continuing medical education, and CPR certification of primary care providers. Importantly, the Monitoring Team assessed the Facility's ability to manage clinical database elements.<br><br><u>Medical Staff:</u> The Facility maintained 1.5 full time equivalent primary care physicians. Both physicians were board certified in family medicine, and were current with continuing medical education (CME). Importantly, physicians participated in CME events specific to developmental disabilities. Both physicians were current with CPR training.<br><br>The Facility had developed a well-equipped medical clinic where individuals were evaluated, and that was supported by a full time clerk and nurse.<br><br>Physicians raised concerns over a recent reduction in nurse case managers from four to two, which they were concerned will negatively impact the care of individuals served; however, since the staffing reduction took place recently, there was no evidence to support this concern. The Monitoring Team will further evaluate clinical outcomes secondary to staffing concerns at future reviews. | Noncompliant |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Management of Health Care Data: The Monitoring Team requested specific data elements, including lists of individuals with conditions such as hypertension, constipation, cerebral palsy, and arthritis. The Facility was unable to provide the information timely or accurately. The Monitoring Team is extremely concerned that the Facility had yet to develop a meaningful process to manage clinical database elements, and notes that compliance with Provision L will require a comprehensive, and meaningful process that enables prompt assessment, and updating of database elements.<br><br>Primary Care Physician Participation with ISP planning meeting: Review of ten randomly generated Individual Support Plans (Individuals #150, #76, #27, #12, #62, #2, #82, #3, #66, #33), generated by the Facility, indicated that the primary care physician participated at four out of ten annual ISP planning meetings (40%). The Monitoring Team believes that primary care providers must be active and regular participants at IDT meetings.<br><br>Routine Care<br>To assess routine care, the Monitoring Team requested the Facility to provide a list of all annual medical assessments that were completed within the past six months, and from that list the Monitoring Team selected the first 15 samples (Individuals #5, #126, #101, #113, #97, #79, #29, #96, #51, #23, #47, #11, #66, #82, and #44) to assess timeliness of the annual medical assessments. Nine out of 15 samples (60%) were completed within two weeks or less of the expected completion date.<br><br>The Monitoring Team reviewed the most recent annual medical assessment completed on all individuals who underwent a bone mineral density study during the past six months (Individuals #116, #23, #24, #11, #46, #26, and #15). Of the seven samples, seven out of seven (100%) demonstrated clinically appropriate physical assessments, and review of systems; seven out of seven samples (100%) listed appropriate ICD-9 diagnosis; zero out of seven (0%) included a comprehensive medical action plan for all relevant diagnosed medical conditions; zero out of seven samples (0%) indicated appropriate cautions for the use physical and mechanical restraint.<br><br>The Monitoring Team is concerned over the lack of complete and comprehensive action plans for known medical conditions. For example:<br>• Individual #15 had a diagnosis of SIADH, which required careful monitoring. The medical plan stated "continue his fluid restriction for his SIADH", and "follow his sodium levels". The IDT must be made well aware of what specifically requires monitoring, and what needs to be reported, as well as how often the sodium should be monitored.<br>• Individual #24 had a diagnosis of degenerative spondylosis; however, there was no medical plan for this diagnosis. In addition, the Individual was prescribed | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | pain medications "as needed" for pain associated with the diagnosis of arthritis, and there was no recommendations on how to specifically monitor for arthritic pain.<br>• Individual #26 had a diagnosis of cerebral palsy (CP), and hemiparesis; however, there was no plan for monitoring progression, or development of secondary conditions that occur in CP. Importantly, the Individual was known to have a history of asthma, but there was no plan on how staff should monitor for potential asthma exacerbation.<br>• There was no effective plan listed for Individual #23's medical issues.<br>• Individual #11 was diagnosed with urinary retention; however, there was no plan for staff to monitor for this condition, and there was no plan for staff to monitor for potential adverse reaction secondary to the Individual's diagnosis of hypotension.<br><br>Specific to medical restraints, the Monitoring Team is concerned that when assessing potential medical contraindications to mechanical and physical restraint, important medical conditions were overlooked, or not considered. For example:<br>• Individual #24 was reported to have no contraindication for restraint; however, the Individual had diagnoses of congenital hip dysplasia, and osteoporosis.<br>• Individual #14 was noted not to have contraindications to restraint; however, the individual was suspected of having cardiomyopathy, and diagnoses of seizure disorder and '.<br>• Individual #26 had diagnoses of hemiparesis and asthma, but was reported not to have a contraindication to restraints.<br>The Monitoring Team is aware that mechanical and physical restraints are necessary in some cases; however, the IDT must be made aware of all potential medical issues that can exacerbate secondary to a physical or mechanical restraint situation, and their specific risks, so alternative and/or adaptive approaches can entertained when developing a restraint plan.<br><br><u>Physician Progress Notes</u><br>The Monitoring Team reviewed the most recent Integrated Progress Notes (IPN) by physicians for ten randomly selected clinical records (generated by computer using "random.org"). Of the ten samples (Individuals #115, #4, #63, #91, #44, #126, #69, #3, 75, and #113), ten out of ten (100%) of the most recent IPNs written by the physician were in a SOAP format, and indicated a clear assessment and plan.<br><br><u>Access to Medical Specialists</u><br>The Monitoring Team discussed with the clinical director and primary care providers the Facility's use, and availability of, medical consultants. The Monitoring Team was | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | informed that Individuals were appropriately referred to outside medical consultants, as needed, and with the exception of orthopedic spine specialists, have no problems arranging for medical consultations. Through review of the active clinical records of Individuals #5, #126, #101, #113, #97, #79, #29, #96, #51, #23, #47, #11, #66, #82, and #44, the Monitoring Team noted appropriate use of outside medical consultants, that were arranged and provided timely.<br><br><u>Preventive Health Care Screening</u><br>To assess the provision of preventive health care at the Facility, the Monitoring Team reviewed clinical records, and requested specific data for screening of osteoporosis, screening mammograms, and screening colonoscopies.<br><br><u>Osteoporosis Screening:</u> The Monitoring Team requested a list of all Individuals who had a bone mineral density (BMD) study completed in the past six months, and was provided a list of seven individuals (Individuals #116, #23, #24, #11, #46, #26, #15). The Monitoring Team reviewed the past 12 months of laboratory studies, DEXA reports, annual medical assessments, and ISPs of these individuals and noted that in seven out of seven (100%), the BMD study was signed and reviewed by the physician; seven out of seven (100%) noted that a TSH, vitamin D, and Calcium level was obtained; seven out of seven (100%) were prescribed vitamin D and calcium supplements; and seven out of seven (100%) noted consideration for the treatment with a bisphosphonate; in zero out of seven (0%) there was no documented evidence to support that the underlying cause of osteoporosis was assessed. The ISP did not document risks and benefits of treating osteoporosis.<br><br><u>Screening Colonoscopy:</u> As part of document request, the Monitoring Team requested, for individuals older than 50, the date of the last colonoscopy, and list reason for colonoscopy, with reason if not up-to-date. The Monitoring Team was not provided the information requested but was given copies of colonoscopies that had been completed on Individuals who reside at the Facility. For this reason, the Monitoring Team was unable to assess if colonoscopy screening were current. The Facility needs to track colonoscopies for individuals older than 50 and reasons if not up-to-date to ensure all appropriate screening is completed. The Facility can use this information to provide quality assurance data on its health care, and can use such data in its self-assessment.<br><br><u>Mammograms:</u> The Monitoring Team requested for those women over 40, the date of their last mammogram, and reason listed if not up to date. The Monitoring Team was not provided the information requested, but was provided a copy of all completed mammograms. For this reason, the Monitoring Team was unable to assess if mammograms were current. The Facility needs to track mammograms for women older than 40 and reasons if not up-to-date to ensure all appropriate screening is completed. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | The Facility can use this information to provide quality assurance data on its health care, and can use such data in its self-assessment.<br><br>Emergency Room Utilization<br>The Monitoring Team requested the integrated progress notes from start of signs/symptoms to transfer to the emergency room (ER), ER report, and copy of orders written by the Facility primary care physician, following the emergency room visit, of the ten most recent ER admissions. The Monitoring Team was provided with nine samples.<br><br>Of the nine samples, four out of nine (44%) included a pre-ER note that described the reason for the ER admission, and included a physical assessment of the individual; four of nine samples (44%) included a post ER follow-up note written by the physician; clear and concise follow-up orders were included in nine out of nine (100%) of the samples.<br><br>Management of Chronic Conditions<br>Seizure Disorder: To assess the Facility's ability to manage seizure disorder, the Monitoring Team requested a list of all individuals diagnosed with seizure disorder, ICD-9 diagnosis of the type of seizure disorder, medication list, date and reason for last neurology consultation, list of all individuals with refractory seizure disorder, who was hospitalized for a seizure disorder, and list of all individuals who have had a vagal nerve stimulator (VNS) implanted, and who were considered for a VNS.<br><br>The Facility reported having 35 individuals with a diagnosed seizure disorder. There were no reports of refractory seizure cases during the previous six months, and no individuals were considered for VNS, or had a VNS implant. Of the 35 individuals with known seizure disorder, 21 out of 35 (60%) had seen a consulting neurologist within the previous six months; ten out of 35 (29%) had a descriptive, ICD-9 diagnosis of their seizure disorder. The Facility reported that only 2.8% of individuals who were prescribed antiepileptic drugs (AEDs) were on three AEDs, and zero out of 35 (0%) were on four or more AEDs. Only six out of 35 (18%) individuals were prescribed older AEDs, such as Phenytoin and Dilantin.<br><br>Hypertension: The Monitoring Team requested a list of individuals with a diagnosis of hypertension, and was provided a list of six individuals who were diagnosed with hypertension. From this list, the Monitoring Team requested the annual medical assessment, cardiology consultations, blood pressure flow sheet, labs for past 12 months, EKGs, and current medication list of all six individuals who were on the list. One of the six individuals that were reported to have the diagnosis of hypertension did not have hypertension, so was eliminated from review.<br><br>Of the five cases reviewed, four out of five medical assessments (80%) included | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | measurement of the individuals waist; five out of five (100%) included a current blood pressure reading, and serial blood pressure readings; five out of five (100%) included either a fundoscopic evaluation, or annual evaluation by an ophthalmologist for retinopathy; four out of five (80%) physical assessments included assessment for edema; five out of five (100%) individuals had an EKG performed within the past 12 months; five out of five (100%) had necessary laboratory evaluations, including lipid panel, TSH, basic metabolic panel, and urine protein assessment; one out of five (20%) documented a review of pulses; and zero out of five (0%) documented an exam for carotid, abdominal and femoral bruits. The Monitoring Team noted marked improvement with the overall management of hypertension.<br><br>Constipation/Bowel Obstruction: The Monitoring Team refers the reader to Provision L2, Mortality Review, of this report, for issues of serious concern with regards to constipation and bowel obstruction.<br><br>Fractures: The Monitoring Team reviewed the Facility's ability to assess, manage, and follow-up on fractures. The pre-visit document request required that the Facility provide a list of all fractures that occurred during the past six months, and the Monitoring Team was provided a list indicating that two individuals had sustained fractures (individuals #94, and #72); however, while on-site, the Monitoring Team asked for a list of all fractures that occurred in the past six months, and was informed that individuals #113, #96, #86, and #40 were the individuals who sustained fractures. The Monitoring Team requested all physician documentation and all IDT reports related to the fractures, as well as any x-rays, hospitalization and consultation reports that may have been obtained. Upon review, it was noted that the fracture that Individual #113 sustained occurred outside this review period, so was not included in this review. The following is a summary, and concerns of the Monitoring Teams review:<br>• Individual #96:<br>Following a chest x-ray for a respiratory condition, the radiologist observed a rib fracture, which the Facility was previously unaware of. The primary care physician promptly reported the incident to the rights officer, and evaluated the individual, documenting a physical examination that was devoid of bruising, swelling, and deformities. Palpation and assessment of pain was not documented. The physician documented that "I have not had any reports of trauma or peer to peer aggression at this point". The physician ordered follow-up rib x-rays. There were no additional follow-up IPNs by the physician. The only ISP documentation provided was an addendum to the ISP, dated 5/23/12, which was conducted on the same day as the rib fracture was identified by the physician. This report did not comment on the fracture, but did report that the Individual had experienced behavioral exacerbation requiring the administration of Ativan for psychomotor agitation, and also reported that the Individual had "slight increase in symptoms and injuries more recently", | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | which were attributed to be "most likely self-caused due to self-bumps". The report also commented on bruising to her arms. The report continued by stating that the Individual's behavior "has been changing in particular for the last 3 days", and that staff reported "crying episodes for about ten minutes. Staff were not able to calm her down." The Team recommended increasing the individual's Ativan to 1 mg, three times per day; monitor for lethargy, unsteady gait and confusion; and to follow-up in two weeks. By review of the attendance sheet, the psychiatrist, but not the primary care physician who diagnosed the rib fracture, attended the meeting.<br><br>The Monitoring Team has serious concerns over the lack of integration by the IDT, especially the integration of medical services evaluation of behavior exacerbations and injuries. The information known to and reported by the IDT should have been well known by all staff who supported the Individual. The primary care physician should have known about the issues related to agitation, crying and bruising. The Psychologist and the psychiatrist should have discussed these issues with the primary care provider, and nursing services should have communicated the issue among themselves, so they would be better able to communicate issues of concern with the primary care provider. The Monitoring Team was also concerned that the physical examination did not document an assessment of pain, or palpation of the ribs.<br><br>• Individual #40:<br>Per an IDT meeting held on 5/29/12, the Individual was known by the IDT to have been experiencing an increase of maladaptive behaviors and had an increase in the dosage of neuroleptic medication on 5/23/12. On 5/29/12, the Individual had sustained a head injury and was "going in and out of consciousness", and was sent to the ER for evaluation. While at the ER, an "incidental fracture" of the thumb was diagnosed. The primary care provider evaluated the Individual following return from the ER. The physician note did not comment on potential pain, and there was no documentation regarding determination of abuse or neglect. Importantly, the note did not comment on the Individual's recent behavior exacerbation requiring increase dosage of the prescribed neuroleptic. The Individual was appropriately referred to an orthopedic surgeon, who followed the Individual through resolution. The Facility physician did not regularly follow-up on this acute issue, through resolution. The addendum to the ISP did not reflect the seriousness of the fracture, or comment on potential abuse or neglect. The primary care provider did not participate at the IDT held to discuss fracture.<br><br>The Monitoring Team noted prompt referral to an orthopedic surgeon by the primary care provider; however, the physician progress note did not document an assessment evaluating for potential abuse issues, and there was no documentation of | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | subsequent follow-up through resolution by the primary care provider. The IDT meetings to address issues related to the fracture, dated 5/29/12 and 6/5/12, did not include the primary care provider.<br><br>Summary:<br>In general, the Monitoring Team has the following concerns regarding the assessment, management, and follow-up to fractures. Medical, nursing, psychiatry, psychology and direct care staff must enhance their integration with regards to medical issues, and behavioral exacerbation. Primary care providers must follow-up, and document their assessment, and plan through full resolution of all acute medical conditions. Pain should always be assessed, and documented when evaluating fractures.<br><br><u>Clinical Case Reviews</u><br>The Monitoring Team observed three individuals at their living area, and conducted a comprehensive review of their active clinical records. The Following is a summary of each review.<br>• Individual #19:<br>The Individual was observed at the living area, and was noted to be leaning in a forward position and having a fixed neck. Review of the clinical record indicated that the Individual had a diagnosis of infantile cerebral palsy, with spastic diplegia, and more recent findings of loss of the ability to ambulate, and worsening spasticity. Review of x-rays indicated that the individual had significant cervical degenerative spine disease; however, degenerative spine disease was not listed on the current annual medical summary, or current active problem list, and CP was listed as a historical diagnosis, and not a current diagnosis.<br><br>The Individual was referred and seen by an orthopedic specialist on 4/10/12, who noted that the Individual "was subjected to years of severe and worsening spasticity", and because of medical risks, surgery would not be a consideration. The Monitoring Team could not identify regular follow-up to assess worsening of spasticity, or secondary manifestations of CP. Importantly, the Monitoring Team could not identify if pain was routinely being assessed for degenerative spine disease. Physical therapy and nursing services did not have action plans in place to address degenerative spine disease, spasticity, or cerebral palsy. The IDT was not made aware of any of these conditions.<br><br>• Individual #35:<br>The Individual was observed at the living area, and was noted to have spasticity. The annual medical assessment dated 12/14/11 noted spasticity on the physical examination. X-rays indicated that the Individual had osteoarthritic changes of the fingers, and degenerative spine disease. Spasticity, degenerative spine disease, and | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | arthritis were not listed as diagnoses on the annual medical assessment or current active problem list.<br><br>The Individual was reported to have abdominal pain and a follow-up test was obtained for H-Pylori. Positive results were returned to the Facility on 8/14/12; however, treatment for H-Pylori, was not initiated until 8/20/12, six days after diagnostic confirmation. The only documentation by the physician specific to this issue was dated 8/27/12, which indicated that the Individual's laboratory study indicated H-Pylori infection and that treatment was started. There was no follow-up documentation through resolution of the symptoms and condition. Importantly, the IDT was not made aware of the diagnosis.<br><br>The Monitoring Team is seriously concerned with the delay in treatment for H-Pylori, a potentially serious condition, that can be very painful, and result in serious maladaptive behaviors. Importantly, H-Pylori can result in severe gastric ulcers that could perforate and cause death. The IDT should have been made well aware of this condition. Serious medical conditions, including degenerative spine disease, osteoarthritis of the fingers, and spasticity, were identified, but not diagnosed on the annual medical assessment or current active problem list.<br><br>• Individual #79:<br>The Individual was observed at day program and was noted to be calm and engaging; however, a lift vest was in-place and two-to-one staff was assigned to support the Individual when ambulating. The Individual was reported and observed not to like walking, and when the Individual did ambulate, ambulation was very fast and unsteady, with a broad based gait. Such issues were not clearly delineated on the annual medical assessment, or active problem list.<br><br>The annual medical assessment dated 3/25/12 noted a decrease in the ability to move the right and left ankle, and documented arthritic changes of the fingers; however, these conditions were not listed as diagnoses, or on the active problem list.<br><br>An abdominal x-ray was obtained to determine placement of a gastric tube on 7/23/12, and demonstrated "large amount of fecal material within the rectum" and "rectal fecal impaction" was diagnosed. The primary care physician at the Facility signed the x-ray, and there was an order written for Colace twice per day, and a Dulcolax suppository, to treat constipation. There was no documented rectal examination by the physician or nurse to determine the significance of the rectal impaction, and there was no follow-up, nor was there an order to increase monitoring by staff for signs and symptoms of worsening bowel issues. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | The Monitoring Team is concerned that important medical conditions were identified by physical examination, but were not included as medical diagnoses, and there was no action plan developed for these conditions. The Monitoring Team is seriously concerned that an x-ray indicated rectal fecal impaction, and medication was prescribed without a physical examination to determine the significance of the impaction, no orders for increased monitoring by staff, and no follow-up by the physician for the diagnosis of rectal fecal impaction. Because the IDT was not made aware of any of these conditions, the Monitoring Team has concern that medical issues are not well integrated into the IDT process.<br><br><u>Conclusion</u><br>The Monitoring Team noted significant and continued improvement with the provision of medical services at the Facility. For example, the physical examinations conducted for annual medical assessments and acute care conditions were more comprehensive; assessing acute medical conditions was occurring more proactively and promptly; consultations were being provided more assertively; and the overall management of seizure disorder meets or exceeds standard of care practice. In general, the Monitoring Team is complimentary to the Facility leadership, staff, and in particular, the medical staff, for their impressive work in moving the Facility closer to substantial compliance. The Monitoring Team did note areas that continue to need improvement, such as ensuring that all identified clinical conditions are listed as an actual diagnosis; ensure that action plans are delineated for each diagnosis, and are comprehensive; and ensure that all chronic care issues are addressed either at a quarterly medical assessment, or as recommended by relevant professional organizations. Although not all medical conditions were evaluated at this review by the Monitoring Team, the Monitoring Team expects that medical conditions, especially those that commonly occur in individuals with developmental disabilities, such as neuromotor, and musculoskeletal disorders, chronic constipation, pneumonia, urinary track infections, and syndromal conditions are assertively managemed. The Monitoring Team is concerned that the Facility had yet to develop a meaningful process to manage clinical database elements, and notes that compliance with Provision L will require a comprehensive, and meaningful process that enables prompt assessment, and updating of database elements. Most important, the Monitoring Team noted significant and serious deficiencies with regards to monitoring, and following up on individuals who were at risk for bowel impaction and obstruction. It is essential that policies, and practices are developed that will ensure appropriate monitoring and follow-up occurs. | |
| L2 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and | To fulfill its obligation in implementing and maintaining a medical review system that consists of non-Facility physician case reviews, the Facility continued with its participation in the Medical Provider Quality Assurance Audit process. Since the last Monitoring Team review, the Facility participated in one External Audit, round 5, | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 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. | conducted on 3/31/12. The Monitoring Team requested copies of all internal and external audit forms, graphs, summaries, action plans, and evidence to support completion of action plans. In addition, the Facility employs an external physician to participate at mortality reviews, and to provide feedback on system improvements based on findings from the mortality review process. The Monitoring Team reviewed the mortality review summary, administrative reports, hospital records, and the clinical record of Individual #54.<br><br><u>External Medical Audits</u><br>The Monitoring Team noted that only one of the two primary care physicians participated with the external audit process, and the scores were noted by the Monitoring Team.<br><br>The external audit assessed issues considered essential, and also non-essential elements. A current list of each element assessed was not provided to the Monitoring Team for review. The External audit noted that the physician was 100% compliant with regards to essential requirements, and no action plans were required to be developed. Two action plans were developed for Non-essential elements, and based on evidence provided, both action plans were not completed at the time of the Monitoring Teams review. The Monitoring Team was provided with several bar graphs but no summary by the Facility, so it was not possible to determine the number or percent of cases reviewed, and there was no information about review of clinical management.<br><br>The Monitoring Team noted significant issues with regards to the external medical audit process. The review process was a specific chart audit process, and because multiple physicians provided services, such as when cross covering, or on-call coverage by alternate physicians, the evaluation process assessed the work of the cross covering physicians, and not just the physician of record. The process continued to be one that reviewed mostly administrative process, such as completing assessments, and timely documentation practices, and did not focus on actual clinical performance. Most important, although the physician gained 100 percent compliance for essential elements, the Monitoring Team noted significant areas of deficiency with regards to provision of medical services, as delineated in Provision L1, of this report.<br><br><u>Mortality Review Process</u><br>The Facility had a death since the last compliance visit, which was the first death reported since the Settlement Agreement was implemented. Individual #54 was a 66 year old female with a history of constipation, bowel obstruction, oral dysphagia, and was rated at high risk for aspiration. She was admitted to Valley Baptist Hospital due to fever, vomiting, abdominal distention and absence of bowel movement for two days. She was diagnosed with bowel obstruction and preparations were being made for an | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | exploratory laparotomy with possible bowel resection when she was found unresponsive and in asystole (cardiac arrest) and died, while at the hospital. An autopsy was performed and the cause of death was: Complications of ischemic bowel, respiratory arrest secondary to aspiration, leading to cardiac arrest, small bowel obstruction and strangulation, and sepsis.<br><br>The Monitoring Team met with the Quality Management Director, Chief Nurse Executive Nurse, Quality Assurance Nurse, and later with the ICF-DD Program Director, and reviewed the Clinical Death Review Committee and Administrative Death Review Committee Minutes, recommendations, as well as other supporting documentation. The Quality Management Director stated the Facility had not had a death in years. Consequently, the Facility did not have a Death Review Policy. They used as a reference the Texas Department of Aging and Disability and Department of Health Services Death Review Policies, in addition to the Facility's Sentinel Event Policy to complete the death review. A Root Cause Analysis and Action Plan in Response to a Sentinel Event were completed. Since different policies were used to conduct the death review process, it was difficult to determine compliance with the policies since all policies contained variations in requirements.<br><br>The Monitoring Team's findings from review of the death information included:<br>• The Department of Aging and Disability and Department of Health Services were notified of the death on the day of the death.<br>• There was a Do Not Resuscitate (DNR) order for full code was in place at the time of the illness and at the time of death.<br>• The manner of death was determined as natural.<br>• An Abuse and Neglect Investigation associated with the death was completed on the day of the death.<br>• An autopsy was completed and finalized seven days following the death.<br>• The Quality Assurance Nurse on 5/30/12 completed the Quality Improvement Death Review of Nursing Services.<br>• A Clinical Death Review was completed by an external physician who was the Investigation Officer, no date included.<br>• The Clinical Death Review Committee met on 6/6/12 with the Administrative Death Committee meeting immediately afterward. Membership for both committees included: Clinical Director, Committee Chaired by Medical Director, External Physician, Investigation Officer, Superintendent, Assistant Superintendent, Program Director, Quality Management Director, Chief Executive Nurse, and Quality Assurance Nurse. The Monitoring Team noted significant concern comprehensiveness of the committee's review.<br>• Recommendations and Plan of Actions were developed from the Clinical and | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Administrative Death Review Committees. The recommendations included plans of actions, responsible parties, and the expected completion date:<br><br>Concerns identified by the Monitoring Team included:<br>• At the time of the compliance review there was documentation that showed only two of five recommendations had been completed. It is essential that recommendations derived from the Clinical and Administrative Death Review Committees are carried out expeditiously to resolve and prevent repeated occurrence of the problems identified, to improve health care services, and to protect individuals from harm. Further, the training material/literature on bowel management and bowel obstruction presented to the medical staff was also relevant to the nursing staff. The Nursing staff should have also been included in the training with the medical staff to enhance their understanding of these critical issues.<br>• The Clinical and Administrative Death Review Committees did not take an integrated and systemic approach to their reviews. The recommendations and plan of actions were directed to the Medical, Nursing, Program Staff, including Direct Support Professional staffs. The death reviews, recommendations, and plan of actions did not include other relevant disciplines.<br>• The Monitoring Team did not agree with the Clinical and Administrative Death Review Committees' findings that the Facility provided Individual #54 with the best possible care and that nothing done at the Facility could have changed the outcome. It is plausible to question if the outcome for Individual #54 would have been different if her bowel elimination patterns had been more closely monitored daily as well as being monitored more closely for bowel obstruction, given her history of bowel obstructions. This opinion was based on review of information from the individual's records and from supporting information about the individual's cause of death and hospitalization.<br>o The Facility did not recognize and/or consider the failure of the nursing staff to follow relevant Nursing Protocols for Vomiting, Constipation, and "When Contacting the PCP". This finding was based on the Monitoring Team's review of the nursing staff's documentation found in the CWS Integrated Progress Notes on 4/12/12, 4/13/12, and 4/16/12. On these dates only the vital signs and oxygen saturations were assessed and documented. There were no assessments of Individual #54's lung sounds, abdomen, or bowel sounds after episodes of vomiting, although she was at high risk for aspiration secondary to oral dysphagia. Neither was there documentation that bowel elimination patterns were assessed, although she had a diagnosis of constipation and a history of bowel obstruction. There was no documentation that the physician was notified of the vomiting episodes on 4/12/12 and 4/13/12. Neither was there follow up assessments documented on at least every shift for 48 hours after episodes of | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | vomiting. Although the Integrated Progress Notes stated, "Will continue to monitor," the notes did not specify how often Individual #54 would be monitored or what was to be monitored. A review of the documents found notes indicating that the physician saw her on 4/12/12 and 4/13/12, although the nurses' notes did not indicate that the physician was notified of the vomiting episodes. On 4/13/12 the physician ordered daily vital signs and bowel movement monitoring to assess for constipation. These orders were in conflict with the Nursing Protocols mentioned above and should not have superseded the requirements for nursing practices included on the Nursing Protocols. The conflict between the Nursing Protocols and physician's orders was not identified in the death reviews. When disparities are identified between accepted standards of nursing practices/protocols and physician's orders, the disparity should be brought to the attention of Nursing Administration for clarification and resolution.<br>o There were no nursing Integrated Progress Notes for the weekend of 4/14/12 and 4/15/12. A review the information supplied found that the physician's notes on 4/16/12 stated that the nurses reported Individual #54 had episodes of vomiting over the weekend. A review of the Nursing Events Daily Logs for 4/12/12 through 4/16/12 found that none of the logs for any of days and shifts reported episodes of vomiting until 4/16/12.<br>o On 4/16/12 at 7:45 a.m., the nurse documented that the a direct support professional staff notified her while Individual #54 was eating in the dining room that she began coughing and vomited. The nurse stayed with her and instructed the staff to have her slow down the pace for eating and drinking. Vital signs were taken in the dining room but the oxygen saturation level was not assessed. The nurse failed to take Individual #54 into the treatment room to complete an appropriate assessment after vomiting. Neither were the lung sounds, abdomen, nor bowel sounds assessed. This was an inadequate assessment to determine if she had aspirated while eating, or if there were bowel related issue. In this note the nurse did documented that the physician was notified, who ordered a chest x-ray and KUB (abdominal x-ray). The physician was to see her in the afternoon.<br><br>The order for x-rays was carried out by RAD Solutions, Inc. at the Facility at approximately 10:00 -10:45 a.m. However, there was a delay in receiving the results until approximately 3:30 -4:00 pm. The results were given to the physician but they were not available for review. There was no further nursing documentation that Individual #54 was monitored on 4/16/12 until 4:30 p.m., when the nurse documented that Individual #54 was brought to the physician's office to be seen for episodes of vomiting and diarrhea. While being seen by the physician she had multiple episodes of vomiting. Vital signs were taken at that | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | time. The physician ordered Individual #54 sent to the emergency room for evaluation by the staff in the Facility van. It was of serious concern that Individual #54 who was experiencing acute distress was sent in the Facility van accompanied by direct support professional staff. This placed Individual #54 at risk of harm because if her condition further declined and required emergency response, the van and the staff were not equipped to handle a frank emergency. This issue was not considered in the by the Clinical and Administrative Death Review Committees.<br><br>While onsite the Monitoring Team found through interviews with staff and review of individuals records and bowel elimination records that the Facility's existing system for monitoring bowel elimination patterns was inadequate and ineffective to protect individuals from harm due to complications of constipation and/or bowel obstruction, which has the potential to lead to death, such as the situation that lead to Individual #54's death. It is essential that the Facility have an effective and reliable system for monitoring the bowel elimination patterns for individuals who are diagnosed with constipation and/or history of bowel obstructions and/or who were rated at high and medium risk for constipation/bowel obstruction.<br><br>A review of the Facility's At Risk Individuals Report, 8/2/12, found that a total of 46 of 70 (66%) individuals were rated at high or medium risk for constipation/bowel obstruction; of which eight of 46 (17%) individuals were rated at high risk and 38 of 46 (83%) individuals were rated at medium risk. The Risk Guidelines, 6/18/12, state: High risk ratings for constipation/bowel obstruction are defined as "Bowel obstruction in the past year. PICA episode in past year requiring removal of foreign object. Manual impaction check that required intervention." Medium risk ratings guidelines for constipation/bowel obstruction state, "History of bowel obstruction in the past three years. Bowel management with diet, routine meds or supplements. Requires routine manual impaction checks." It is essential that all individuals with high and medium risk ratings have daily monitoring of their bowel elimination patterns.<br><br>A review of the Facility's Hospitalization and Emergency Room Visit Record 2012 found there were four emergency room visits for three individuals, of which one resulted in admission to the hospital, for nausea, vomiting and abdominal pain, who were subsequently diagnosed and treated for constipation and/or fecal impaction removal. For example:<br>• Individual #80 was rated at high risk for constipation/bowel obstruction and had one emergency room visit.<br>• Individual #126 was rated at high risk for constipation/bowel obstruction and had two emergency room visits, one of which resulted in hospitalization. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • Individual #1 was rated at medium risk for constipation/bowel obstruction and had one emergency room visit.<br>It is plausible to question whether their complications of constipation and fecal impaction that resulted in nausea, vomiting, and abdominal pain, as well as the expense of emergency room treatments, been avoided if these individuals had had their bowel elimination patterns checked daily?<br><br>The Program Director explained to the Monitoring Team that a couple of months ago she had developed and implemented a system for the staff to enter individuals' daily bowel eliminations reports into CWS. However, when the Monitoring Team attempted to find copies of individuals' bowel elimination records, the Direct Support Professional Supervisor staff gave differing answers regarding the requirements for monitoring individuals' bowel elimination patterns. One staff said not everyone was monitored, only those who had physician's orders for monitoring. Another staff said only the high risk individuals were monitored. When the nursing staffs in both Units were asked for bowel monitoring records for Individuals #29, #72, #126, #143, #98, #97, #33, #140, #40 and #77, who were rated at high or medium risk for constipation/bowel obstructions, it was apparent they were not routinely monitoring bowel elimination patterns and were not aware of a procedure for doing such. The Nursing Offices had binders with some of the paper copies of individuals' Daily Bowel Movement Monitoring Records. Only two of 10 (20%) had such records in the binders, and it was further apparent the nursing staff were not checking these records daily. Then, when the nursing staffs in both Units were asked to check in the bowel elimination records in CWS, none of the nurses knew how to access these records and seemed unaware that they should be daily checking the records in CWS. The Nurse Educator showed the nursing staff how to access the records in CWS. The 10 individuals' records were checked for the period of 8/23/12 through 8/30/12. The results of the checks found that seven of 10 (70%) had either had no documentation for bowel elimination patterns or were recorded as zero or no bowel eliminations for five to eight days. Although the concept of entering daily bowel elimination records in CWS was a positive step, it is a worthless effort unless the Facility has a standardized/formalized procedure for daily monitoring of bowel elimination patterns and that the Nursing Staff and Program Staff, including the Direct Support Professional Staff, are competency-based trained on the procedure, as well as how to access the information in CWS. In addition, the Facility should put a monitoring system in place to ensure bowel elimination patterns are monitored daily. It is essential that the Facility Program Director and Chief Nurse Executive urgently address this issue to protect individuals from potential complications related to constipation and bowel obstruction.<br><br><u>Conclusion</u><br>Because the Facility had yet to fully implement a process that enabled an assessment of the primary care physician clinical performance, and because of an ineffective mortality | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | review process, that did not identify important system issues related to a recent death at the Facility, and did not have appropriate policies and procedures for conducting mortality reviews, the Monitoring Team determined that the Facility remains not-in-compliance with Provision L2. As noted in this report, the Facility must address important system issues that were identified by the Monitoring Team. | |
| L3 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved. | The Monitoring Team requested all information related to a medical quality assurance process, and any systems improvement measures that the Facility had developed and implemented, and was only provided copies of outcomes related to internal medical audits.<br><br>Internal medical audits were conducted using the same tools and format as the external medical audits, described in Provision L2 of this report. Both practicing primary care providers participated in the internal medical audit process, which was conducted throughout June and July 2012. Because the Monitoring Team was not provided with a summary of the audit process, the Monitoring Team could not determine the number of case examples used for the audits, nor could it determine what specific clinical elements were assessed for the audits. Graphs provided for the audit process indicated that both physicians attained 100 percent compliance with regards to essential elements, and the Monitoring Team has the same concerns, as outlined in Provision L2 of this report for the external medical audit process, and does not believe that the internal medical audit process enables a meaningful assessment of clinical outcomes. Furthermore, the medical director reported that the Facility did not track or trend specific medical indicators, which would be used to enhance clinical outcomes.<br><br>Because the Facility did not have a process in place that would enable a systems review of clinical outcomes, the Monitoring Team concurs with the Facility and determined that it remains non-compliant with Provision L3. | Noncompliance |
| L4 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing | The Monitoring Team requested all information specific to policies and procedures that were developed and/or implemented since the last compliance review. The medical director informed the Monitoring Team that now new policies have been implemented, and the current existing policy standard operating procedures had not been fully implemented.<br><br><u>Standard Operating Procedure, ICF-MR 400-14, dated December 9, 2010</u><br>The Monitoring Team re-reviewed the Facility's Standard Operating Procedure, and noted no changes in clinical practice that would indicate the policy had been implemented, and same areas of concern as at the last compliance visit remain. For example, Procedure I.A states that the clinical care and treatment is provided in an | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | 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 QDDP 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 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.<br><br><u>Conclusion</u><br>The Monitoring Team concurs with the Facility's self-assessment of noncompliance because it did not have effective policies and procedures to help ensure that the provision of medical services meets or exceeds standard of care practice. The Facility must review its clinical processes and develop, and implement meaningful medical policies. | |

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

1. Physicians must be an active, and regular member scheduled IDT meetings, or have a mechanism that enables effective communication of all relevant issues. (Provision L1)
2. Annual medical assessment must be completed timely. (Provision L1)
3. Medical action plans must be developed for all acute and chronic medical conditions, and must comprehensive enough to ensure that the IDT members clearly understand monitoring and follow-up issues related to each medical condition. (Provision L1)
4. Physicians must inform the IDT of all potential risks to restraint, secondary to underlying medical conditions. (Provision L1)
5. The Facility must attempt to assess the cause of low bone density, prior to starting treatment. All risks and benefits of treating low bone density, including no treatment, must be considered by the IDT. (Provision L1)
6. The physician must ensure that a post ER admission note be completed upon return of the Individual to the Facility, and that the note clearly describes ER assessments, diagnosis, concerns, and plan. (Provision L1)
7. Ensure that the management of all chronic conditions, such as hypertension, includes standard of care follow-up, as recommended by relevant medical associations, or peer supported literature. (Provision L1, L3, and L4
8. When assessing medical conditions that may precipitate pain, physicians must assess for pain, and provide the IDT with clear instructions on how and what to monitor for pain, specific to each individual and condition.
9. All medical conditions delineated in consultation and diagnostic reports, and those identified by physical examination by the primary care physician, must be listed as a diagnosis on the annual medical assessment and active problem list, when clinically appropriate. (Provision L1)
10. The Provision of medical services, especially when treatment is needed for an acute condition must be provided timely.
11. The Facility must ensure that all musculoskeletal and neuromotor conditions, such as spasticity, cerebral palsy, arthritis, and degenerative spine

disease, be assessed by necessary specialists, appropriately treated, and regularly followed-up. (Provision L1)

12. The physician must provide comprehensive assessment of chronic constipation, impaction and obstruction and regularly follow-up through full resolution, and prn medication must be carefully monitored by the nurse and physician. (Provision L1)
13. Develop and implement a mechanism to manage clinical database elements that enables prompt assessment and updating of clinical data. (Provision L1 through L4)
14. Ensure that all medical conditions, including those that commonly occur in individuals with developmental disabilities, are assertively managed. (Provision L1 through L4)
15. The Facility must enhance its mortality review process, as delineated in Provision L2, of this report, and ensure that deficient system issues are appropriately identified following each mortality review, and that meaningful action plans are developed to enhance clinical practice, whenever necessary. (Provision L1 through L4)
16. The Facility must immediately enhance its ability to track and trend bowel movements of individual at risk for impaction and obstruction, and to ensure prompt medical assessment and treatment of all individuals who experience signs and/or symptoms of bowel obstruction. (Provision L1 through L4)
17. The Facility must develop and implement a robust medical quality assurance process that will enable the tracking and trending of medical indicators and enable improvements with clinical processes at the Facility. (Provision L3)
18. The Facility must develop and implement policies and procedures that clearly delineate practice standards that reflect standard of care practice. (Provision L4)

The following are offered as additional suggestions to the Facility:

1. Ensure nurse case manager staffing is adequate to support the needs of individuals served. (Provision L1)
2. The Monitoring Team did not assess pneumonia, or syndromal conditions at the Facility during this review period; however, all cases of pneumonia must be carefully assessed, to determine the root cause of the pneumonia, and preventive measure must be implemented, when possible. The Facility must ensure that they are aware of all syndromal conditions at the Facility, and ensure appropriate monitoring, treatment, and follow-up is in-place for known conditions related to each syndrome. (Provision L1, L2, and 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:**<br>**Documents Reviewed:**<br>1. RGSC Section M Self-Assessment, 8/13/2012<br>2. RGSC Section M Action Plans, 8/9/2012<br>3. RGSC Entrance Presentation Handout, 8/27/2012<br>4. RGSC Section M Presentation Book<br>5. RGSC Infection Control Monthly Infection Report, Standard Operating Procedure, EC402-03, Revised: October 2011<br>6. RGSC Environmental Surveillance Techniques, Standard Operating Procedure EC 403-03, Reviewed/revised: October 2011<br>7. RGSC Quarterly Data Tally Sheet, Performance Improvement Indicators, Standard Operating Procedure, EC401-05, Revised: October 2011<br>8. Texas Department of Aging and Disability (DADS) State Supported Living Center (SSLC) Procedure: Medication Administration Guidelines, Date: February 2011<br>9. RGSC Medication Administration Guidelines, Standard Operating Procedure NR 400-08, Date Established: April 2011<br>10. DADS – SSLC Procedure: Medication Variances/Incidents, No number or date<br>11. RGSC Nursing Tentative Meeting Schedule for August 2012<br>12. RGSC Nursing Department Organizational Chart<br>13. RGSC Nursing Department List of Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) Positions<br>14. RGSC Monthly Nursing Services Staffing Analyses for all shifts for March 2012 through May 2012<br>15. RGSC Summary of Nursing Services Staffing Reports, February 2012 through May 2012<br>16. RGSC Nursing Services Minimum Levels, Fiscal Year 2012<br>17. RGSC Monthly Nursing Meeting Minutes, March 2012 through July 2012<br>18. RGSC List of RN Case Managers' Current Caseload<br>19. RGSC At Risk Individuals Report, Dated : August 27, 2012 through August 31, 2012<br>20. RGSC Hospitalization Record for 2012<br>21. RGSC List of Individuals with Diagnosis of Pneumonia since February 2012<br>22. RGSC Medical Emergency Response Drill Instructor Competency Exam and Training Rosters<br>23. RGSC Completed Medical Emergency Drill Checklists, March 2012 through July 2012<br>24. RGSC Medical Emergency Checklist Analysis Summary, February 2012 through July 2012<br>25. RGSC Medical Equipment Location List, February 2012 through July 2012<br>26. RGSC List of Staff Responsible for Mock Medical Emergency Drills, February 2012 through July 2012<br>27. RGSC Summary of Mock Medical Emergency Drills, for June 2012<br>28. RGSC Team Integration Meeting (Morning Medical Meeting) Minutes, 8/28/2012<br>29. RGSC Departmental Performance Measures, Fiscal Year 2012, Third Quarter<br>30. RGSC Antibiotic Susceptibility of Common Organisms, January through December 2011<br>31. RGSC Comprehensive Preventive Health Database for ICF, Dated: 8/28/2012<br>32. SSLC TB Testing Compliance – Action Plan Due by July 2012, email to Infection Control Nurses from State Office Nursing Coordinator, Dated: 6/22/2012 |

| | |
|---|---|
| | 33. State Supported Living Center (SSLC) Facility Tuberculosis (TB) Compliance Reports for Individuals and Employees, Dated: May 2012<br>34. RGSC Facility Tuberculosis (TB) Monthly Report, Dated: 7/13/2012 and 8/17/2012<br>35. RGSC Immunization Database, Dated 8/28/2012<br>36. RGSC Infection Control Program – Quarterly Improvement Indicators<br>37. Texas Department of State Health Services, Texas Notifiable Conditions, E59-11364 (Rev. 01/12), Expires 1/31/2012<br>38. Center for Disease Control (CDC) Definitions of Nosocomial Infections<br>39. RGSC Monthly Infection Control Reporting Form IC-1 (reports of all infectious/communicable diseases), Dated: March through July 2012<br>40. RGSC Infection Control Monthly Surveillance Checklist , 6/25/2012<br>41. RGSC Memorandum Regarding Chart Review of Immunizations, 7/13/2012<br>42. RGSC Memorandum Regarding Infection Control Surveillance, 6/25/2012<br>43. RGSC Monthly Safety/Risk Management/Infection Control Committee Meeting Minutes, February 2012 through May 2012<br>44. RGSC List of Employees Trained on Infection Control, July 2011 through July 2012<br>45. RGSC Medication Management Workgroup Meeting Minutes, 5/29/2012<br>46. RGSC Nursing Competency Process<br>47. RGSC Nursing Competencies for Calendar Year 2012<br>48. RGSC Nursing Competency Database, and Associated Training Data, February through June 2012<br>49. RGSC Pharmacy and Therapeutics Sub-Committee Meetings Minutes, Dated: 6/13/2012<br>50. RGSC August 2012 – Medication Error Trend/Analysis for Third Quarter Fiscal Year 2012<br>51. RGSC Medication Administration Observation Process<br>52. RGSC Medication Administration Observation Schedule for 2012<br>53. RGSC Medication Administration Observation Tracking Databases for First, Second and Third Fiscal Quarters 2012<br>54. RGSC Monthly CATW2s for January 2012 through June 2012<br>55. RGSC Monthly Medication Error Investigation Reports, February 2012 through May 2012<br>56. RGSC Nursing Processes for:<br>a. Mini-Kardex (El Paisano and La Paloma)<br>b. Physician's Orders<br>c. Labs<br>d. Ninety Day Updates<br>e. Daily Vital Signs<br>f. Bowel Monitoring Form<br>g. Charge Nurse Checklist (also known as the Medicine Room Checklist)<br>57. RGSC Nursing Process for Labs<br>58. Discharge/Transfer Nursing Assessments for Individuals: #115, #145, #121, #13, and #80<br>59. Sample Hospitalization Records for Individuals: #19 and #26<br>60. Sample Seizure Records for Individuals: #72, #86, #47, #118, #98, #19, and #60<br>61. Sample of Acute Care Plans for Skin Integrity Problems and Associated documentation for Individuals: #126, #47, and #139 |

| | |
|---|---|
| | 62. Sample of Acute Care Plans for Acute Change in Health Status for Individuals: #67, #2, #75, #62, #40, #127, and #3<br>63. Sample of Health Management Plans for Individuals: #27, #96, #5, #36, #87, #61, #3, #40, #44, #132, #140, #133, and #40<br>64. Sample of Aspiration Triggers Data Sheets and Associated Integrated Progress Notes for Individuals: #29, #47, #126, #72, #51, #143, #98, #140, #33, and #97, and #5<br>65. Sample of Integrated Risk Ratings and Action Plans for Individuals: #1, #3, #27, #66, #8, #96, #23, #140, #126, #75, and #145<br>66. Sample of the TRUE TRACK Blood Glucose Monitoring Daily Quality Control Records, April through July 2012, for Individuals: #140, #139, #33, #150, #108, #5, and #82<br>67. Sample of Seizure Records for Individuals: #72, #86, #47, #118, #98, #19, and #60, March through August 2012<br>68. Sample of Discharge Nursing Summary for Community Living Discharge Planning for Individuals: #115, #145, #121, #13, and #80<br>69. Sample Records for Individuals with Multiple High and Medium Risk Ratings, Individuals: #5, #141, #29, #72, #119, #140, #51, and #126<br>70. Sample of ACPs for Individuals #67, #2, #26, and #75<br>**People Interviewed:**<br>1. Yolanda S. Gonzalez, RN, Chief Nurse Executive (CNE)<br>2. Albert Weaver, RN, Nurse Educator<br>3. Jamie Rodriguez, RN, RN Case Manager for El Paisano<br>4. Eva Lujano, RN, RN Case Manager for La Paloma<br>5. Susana Garcia, RN<br>6. Rodger Garza, RN<br>7. Connie Franco, LVN<br>8. Norma Araiza, LVN<br>9. Susan Atzividitis, LVN<br>10. Drena Barrientes, LVN<br>11. Jessica Juarez, RN, Infection Control Preventionist (ICP)<br>12. Michael Robinson, RN, Quality Enhancement Nurse (QE)<br>13. Maria Dill, MD, Medical Services<br>14. Lorraine Hinrichs, ICF-DD Program Director<br>15. Ricky Zuniga, Interim Vocational Services Manager<br>16. Numerous Staff Nurses and Direct Care Professionals<br>**Meeting Attended/Observations:**<br>1. Review of Section M Presentation Book with Chief Nurse Executive, Nurse Educator/Unit Nurse Manager, RN Case Managers, and Quality Enhancement Nurse, 8/27/2012<br>2. Morning Medical Meeting, 8/28/2012<br>3. Infection Control Program with Infection Control Nurse, 8/28/2012<br>4. Mock Medical Emergency Drill Meeting with Interim Vocational Services Manager, 8/28/2012<br>5. Pharmacy and Therapeutics Committee Meeting, 8/29/2012<br>6. Medication Administration Observations in La Paloma and El Paisano, 8/29/2012 |

| | |
|---|---|
| | 7. Annual ISP Meeting for Individual #141, 8/30/2012<br>8. Numerous tours in La Paloma and El Paisano throughout the compliance review |
| | **Facility Self-Assessment:**<br>RGSC's Self-Assessment, updated 8/13/12 and the Action Plan Updated 8/9/12, provided assessment of activities engaged, in and their status for Sections M's Provisions M.1 through M.6 of the Settlement Agreement. The Self-Assessment reviewed and analyzed data to evaluate their level of compliance with the Settlement Agreement.<br><br>Although most of the areas assessed and analyzed related to some requirements of the Settlement Agreement but not all requirements were assessed, as are described throughout all Provisions of the report. Most of the areas were in response to previous recommendations made by the Monitoring Team. However, these areas were not the only areas necessary to demonstrate substantial compliance. The Facility should look at the total requirements necessary for substantial compliance and self-initiate and implement action steps to move forward toward substantial compliance. Some of the Self-Assessment data were difficult to understand and interpret. It was of concern that some of the Action Steps were initiated in 7/2/11 and were still in process. Other Action Steps were not projected for completion until 5/31/13.<br><br>The Facility self-rated itself as in noncompliance with Provision M.1 through M.6, the Monitoring Team concurred with the findings of noncompliance. |
| | **Summary of Monitor's Assessment:**<br>Overall, RGSC did not appear to be moving forward in a positive direction with regard to providing nursing services. This most like was attributable to the 45% turnover rate of the nursing staff, particularly the nursing administrative and management staff, coupled with the necessity to rely on approximately 50% contract nurses to provide direct nursing services.<br><br>Provision M.1: This Provision was determined not to be in compliance. This Provision is an overarching Provision that covers multiple nursing functions and other areas that are not exclusively related to nursing services. The major concern identified at this compliance review was the 45% turnover rate of the nursing staff, particularly the nursing administrative and management staff, coupled with the necessity to rely on approximately 50% contract nurses to provide direct nursing services, which appeared to negatively impact all Provisions, as reported throughout the report.<br><br>Provision M.2: This Provision was determined not to be in compliance. The nursing assessment failed to summarize concisely and succinctly individuals' health status progress in relation to their identified risk ratings and/or active medical problems that required nursing interventions. The two recently hired RN Case Managers need additional training and experience with these processes. They had not received the mandatory Physical Assessment and Documentation Class. The class was scheduled for some time in September 2012.<br><br>Provision M.3: This Provision was determined not to be in compliance. The care plans developed and |

| | |
|---|---|
| | implemented in relation to individuals' identified risk ratings and/or active medical problems were not individualized sufficiently to meeting individuals' specific needs. The recently revised Integrated Risk Rating Form and Integrated Health Care Planning Process was still evolving. The two recently hired RN Case Managers need additional training and experience with these processes.<br><br>Provision M.4: This Provision was determined not to be in compliance. The Nurse Educator continued to maintain a Nursing Training Tracking Database to verify the required nurses' training. However, the significant turnover in nursing administrative and management staff negatively impacted the Nurse Educator's ability to effectively provide and monitor the effectiveness of training because he was also filling in as the Nursing Operations Officer, Unit Nurse Manager, and at times as a direct care nurse.<br><br>Provision M.5: This Provision was determined not to be in compliance. Compliance with this Provision requires the collaboration and integration of nursing with all disciplines in the identification of individuals' risk ratings and risk action plans. The recently revised Integrated Risk Rating Form and Integrated Health Care Planning Process was still evolving. The two recently hired RN Case Managers need additional training and experience with these processes.<br><br>Provision M.6: This Provision was determined not to be in compliance. The Facility had not adopted and implemented the final Medication Variance Policy, 053. The Facility needed to further analyze medication variance data to ensure that all medication variances, committed by all disciplines, are identified and appropriate corrective action taken to prevent and/or minimize their reoccurrence. While the nursing staff had a general knowledge of dysphagia, they lacked the knowledge to fully understand and implement strategies related to PNM to ensure safe medication administration practices. |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| 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. | Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>• Staffing Analyses were reviewed to ensure that minimum staffing ratios were maintained (number of Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) per home per shift).<br>• Reviewed six records per month for 24 Hour Record Checks audits to ensure physician orders were followed through to completion.<br>• Completed one Section M Nursing Care: Annual Nursing Care Plan Monitoring Tool per case manager each month, for a total of three monitoring tools.<br>• Reviewed Mock Medical Emergency Drills.<br><br>From its self-assessment the Facility determined that:<br>• The Nursing Department completed monthly staffing analyses to identify staffing needs that included: Nurse staffing ratios, nurse supplemental coverage and contract nurse staffing, and vacant positions. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • The Staffing Report for 02/29/2012 showed the nursing staffing ratios in homes did not fall below the established minimum ratios during the month. A RN Case Manager resigned. The Nurse Operating Officer (NOO) was on medical leave. A Unit Nurse Manager was hired. The Hospital Liaison Clerk was assigned to work in Medical Outpatient Clinic with physicians. A LVN III was on leave.<br>• The Staffing Report for 03/31/2012 showed the nursing staffing ratios in homes did not fall below the established minimum ratios during the month. A LVN III was hired. One RN II resigned. Interviewed A-Best contract nurses. The NOO and Hospital Liaison Clerk resigned. Interviewed a contract RN for Medical Outpatient Clinic.<br>• The Staffing Report for 04/30/2012 showed the nursing staffing ratios in homes did not fall below the established minimum ratios during the month. The Nursing Department's Clerk IV assumed role of Hospital Liaison Clerk position in Medical Outpatient clinic. Two RN Case Managers resigned. One RN Case Manager transferred from Mental Health Units. One RN II and one RN Case Manager were hired. The Unit Nurse Manager went on leave. The Nurse Educator assumed the responsibility for staffing schedules and Unit Nurse Manager role.<br>• The Staffing Report for 05/31/2012 showed the nursing staffing ratios in homes did not fall below the established minimum ratios during the month. One RN Case Manager was hired, who transferred from the Unit Nurse Manager role. The Medical Outpatient Clinic was staffed with a contract LVN and Hospital Liaison Clerk. Unit Nurse Manager position was vacant. A new NOO was hired. Interviewed A-Best contract nurses. Nurse Educator continued in the Unit Nurse Manager role. A RN II and LVN III served on jury duty during the month.<br>• The Staffing Report for 06/30/2012 showed the nursing staffing ratios in homes did not fall below the established minimum ratios during the month. One Case Manager was on leave. Interviews for the Unit Nurse Manager position were conducted, two offers were declined. Hospital Liaison Clerk hired. Nurse Educator continues in the UNM role.<br>• The Staffing Report for 07/31/2012 showed the nursing staffing ratios in homes did not fall below the established minimum ratios during the month. The recently hired NOO resigned. The Unit Nurse Manager position remained vacant. Nurse Educator continued to serve in Unit Nurse Manager role.<br>• Findings from the 24 hour record checks to verify if orders are followed through to completion (24 hour record check audit) are as follows:<br>o 02/29/2012 - 68% of appointments attended.<br>o 03/31/2012 – 63% of appointments attended.<br>o 04/30/2012 – 68% of appointments attended.<br>o 05/31/2012 –73% of appointments attended.<br>o 06/30/2012 – 78% of appointments attended. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | o 07/31/2012 - 72% of appointments attended.<br>• The Section M Nurse Care: Annual Care Plan Monitoring Tools completed, one per RN Case Manager, showed:<br>o 04/30/2012 – One monitoring tool was completed.<br>o 05/31/2012 – Three monitoring tools were completed.<br>o 06/30/2012 - Three monitoring tools were completed.<br>• There was one RN Case Manager left on staff after three of the four RN Case Managers resigned within a two month period. On 5/16/2012, the two new RN Case Managers were trained by the Quality Enhancement Nurse on completion of the Monitoring Tools. After consulting with Quality Management Director, a decision was made to complete one monitoring tool for 04/30/2012.<br>• The Mock Medical Emergency Drill Results were reviewed on 07/11/2012, during the monthly Nurses' Meeting. The NOO reinforced the importance of timely response to the Mock Medical Emergency Drills and to have emergency equipment readily available. Medical Emergency Equipment was located and maintained at Vocational Services and in both homes. Findings from 06/2012 drills included:<br>o Seven Mock Medical Emergency Drills were conducted. Seven of 7 (100%) drills had a response time of 10 seconds or less. Two of 7 (29%) drills required follow-up action to replace the oxygen tanks due to low pressure.<br><br>Based on the findings of the self-assessment, the Facility determined this Provision was not in substantial compliance because the consistent use of Section M Monitoring Tools was not in place, and the data available did not demonstrate that health care problems, medical emergencies, and acute situations were managed consistently.<br><br><u>Monitoring Team Findings:</u><br>Provision M.1 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, development, and implementation of health care plans is found below in Provision M.2 and M.3 reports. Information and recommendations about nursing documentation regarding restraints is included above in Provisions C.5 and C.6 of the report. Information and recommendations regarding nursing documentation for the death review process is reported above in Provision L.2.<br><br>The Facility's Provision M.1 Self-Assessment stated they were not in compliance with this provision and the Monitoring Team concurs. A review of the Provision. M.1 Self-Assessment, Section M Presentation Book, staff interviews and review of documents, | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | provided showed that the Nursing Department had made negligible progress in some areas of compliance and minimal progress toward achieving compliance in other areas of the various requirements contained in this provision.<br><br><u>Staffing</u><br>At the time of the compliance 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. The CNE position was not included as one of the 21 nursing positions. Of the RN positions, one served as the QE Nurse and the other served as the Physical Nutritional Management Team (PNMT) Nurse and were not counted as part of nursing services' staffing. Two RNs and one LVN positions were vacant. Fifteen agency nurses were used to supplement vacancies and fill in for staffing shortages; of which there were 11 RNs and four LVNs.<br><br>Since the last compliance review, the Nursing Department had a 45% turnover rate in their nursing administrative and management staffs. It was apparent from observations, interviews, and review of documents that this high turnover rate had a significantly negative impact on moving the Nursing Department forward in complying with each of this section's provisions of the Settlement Agreement. Due to the significant turnover rate in the past six months it is plausible to question what led to the significant turnover. In order to retain and recruit nursing staff the Nursing Department should evaluate the reason for the significant turnover rate of the top nursing administrative/management staff and determine whether any actions could be taken to reduce turnover. It is essential that the Nursing Department maintain a stable and competent nursing administrative/management staff to sufficiently to meet individuals' health care needs. At the present time, it was questionable if those needs were being met. Most concerning were vacant positions for the NOO and the Unit Nurse Manager. The Nurse Educator, in addition to his responsibilities, was also serving in the capacity of the NOO, Unit Manager, and sometimes as a staff nurse. Although he was extremely motivated and dedicated to fulfilling these responsibilities, as one staff it would appear most difficult, if not impossible, to effectively keep up with all of the areas of responsibility.<br><br>Another concern was the elimination of two of the four RN Case Manager Positions. The loss of the two RN Case Managers resulted in an increased caseload of 35 individuals per RN Case Manager; this is a larger caseload than seen at other facilities reviewed by this Monitoring Team. Recently, two experienced and motivated RN Case Managers were hired and were in the process of adapting to their roles and responsibilities. The Monitoring Team requested copies of the RN Case Managers' functional job roles and responsibilities, along with their training records. However, these items were not made available for review. Considering the degree of responsibility inherent in RN Case Manager role, it is questionable with the large caseload whether the recently hired RN | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Case Managers will be able to adequately/sufficiently meet the needs of individuals with complex medical/and health needs with a caseload of 35 individuals. The La Paloma Unit collectively had the highest number of individuals with high and medium risk ratings and was the more medically complex of the two Units.<br><br>A review of the past six months staffing analyses showed that the established nursing ratios were met. However, there was heavy reliance on agency staff to provide direct nursing services. Exclusive of five full time nursing administrative/management positions, there were 14 full time nursing positions (six RNs and eight LVNs) to provide direct nursing services 24 hours a day seven days a week. Because 15 agency nurses were used to supplement staffing the adequacy of budgeted nurses was questionable. The Nursing Department should make every effort to secure additional nursing positions and continue to recruit and retain full time nursing staff.<br><br><u>Quality Enhancement Efforts</u><br>Since the last compliance review, the Nursing Department's quality enhancement efforts for completing the Nursing Monitoring Tools had regressed due to the high turnover rate of nursing management staff. The two recently hired RN Case Managers were trained on 5/16/12 by the QE Nurse on conducting audits on the Nursing Monitoring Tools and were still in the learning process. The CNE and QE Nurse agreed that monitoring tool data was not yet reliable. There was no process in place for conducting inter-rater reliability between the nurses and the QE Nurses. The QE Nurse, who was hired six months ago, stated the quality enhancement efforts were evolving. He provided a description of the quality enhancement activities he was responsible for completing. The QE Nurse was responsible for overseeing monitoring activities for medical, pharmacy, and nursing services at the Mental Health Hospital, the Outpatient Clinic, and Intermediate Care Facility. He stated his next six month focus would be on nursing services. It is essential that the RN Case Managers gain competency in conducting Nursing Monitoring Tool audits in order to ensure accuracy and to demonstrate the status of compliance with each tool. Since there was no reliable data on the Nursing Monitoring Tools available to review, progress toward compliance with all Nursing Monitoring Tools will be followed-up at the next review. The Nursing Department should ensure that all Nursing Care Monitoring Tools are completed according to schedule, sent to the Quality Enhancement Department to enter into the Quality Enhancement Database, analyzed, and trended for compliance. For the tools falling below 90%, a systemic CATW2 should be developed, implemented, and followed through to resolution.<br><br>It was positive to find that the Nursing Department was conducting monthly audits on the 24 Hour Record Checks and Appointment System to verify that Physician Orders were carried through to resolution; individuals' medical and dental appointments were | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | scheduled, kept and/or rescheduled, and kept. A review of the audit data found that the monthly audits for the past six months consistently fell below 100% compliance, i.e., compliance varied between 63% and 78%. It is essential that 100% compliance is consistently achieved for carrying out Physician Orders and ensuring that individuals' appointments are kept. It was plausible to deduce that the low percentage of compliance for these issues was attributable to the high turnover rate of nursing management and the clerical staff who maintained the appointment system data base, assisted the nursing staff in scheduling appointments, and notified the nursing management staff when appointments were not kept.<br><br><u>Assessment and Documentation of Individuals with Acute Changes in Status</u><br>Since the last compliance review, the Facility had continued to conduct an integrated team meeting during the Morning Medical Meeting. The Monitoring Team attended the meeting on 8/28/12. There were no hospitalization or hospital visits in El Paisano. A report was given on a post hospitalized individual in La Paloma. Other updates were provided on individuals' health/medical events occurring over the past 24 hours. Concerns identified by the Monitoring Team as a result of the Integrated Team/Morning Meeting included:<br>• Individual #26 was discharged from the hospital on 8/27/12; this individual was diagnosed and treated for dehydration and tachycardia. Her hospital course was discussed by the team. Her Qualified Developmental Disability Professional (QDDP) was to schedule a post hospitalization staffing meeting. However, later in the day the Monitoring Team discussed Individual #26's proposed post hospital staffing with her RN Case Manager and found that she was not aware that a staffing meeting had been scheduled. There was no further notification that Individual #26's post hospital staffing had been scheduled. Therefore, it could not be determined if the staffing meeting occurred.<br>• It was reported that Individual #126 was still having loose stools. The physician stated he believed it was a functional cause, but was unsure. There was no further exploration or discussion regarding the underlying cause of the loose stools. Considering the potential for individuals to have loose stools around the complication of fecal impaction/bowel obstruction, it was of particular concern since the Monitoring Team identified that the Facility was not consistently checking individuals' daily bowel elimination patterns, as reported in Section L, Provision L.2. Of course there are numerous other causes for loose stools that should be evaluated and ruled in or out. Persistent loose stools (diarrhea) have the potential to cause complications, such as, dehydration, malnutrition, hypokalemia, and anemia.<br><br>It was positive to find that the Medical Director had started providing the integrated team in-service education on a variety of pertinent topics: Skin Care was presented on 8/24/12 and Tardive Dyskinesia was presented on 8/28/12. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | In general there was no improvement in the assessment and documentation of individuals with acute changes in status. From a review of individuals' records, the following problematic trends continued to be found as in past reviews:<br>• The revised 24-Hour Event Logs did not consistently include pertinent information for the nursing staff to follow up on shift to shift.<br>• Lack of documentation in the Integrated Progress Notes and other records made it difficult to determine when changes in health status initially occurred.<br>• Lack of complete and appropriate nursing assessments in individuals' response to presenting signs and symptoms of changes in status; and/or changes in vital signs and oxygen saturation measurements. Including inconsistent lung and/or bowel sound assessments for respiratory and gastrointestinal issues.<br>• Lack of follow-up of issues noted in previous nurses' progress notes.<br>• Lack of specific description of physical appearance, size, and location of skin rashes, injuries and/or bruises.<br>• Lack of documentation regarding activity tolerance for activities during the day for individuals' experiencing or recovering from an acute illness or injury.<br>• Inadequate documentation of the administration and follow-up response of PRNs (as needed medications).<br>• Lack of mental status assessments documented during status changes and/or specific descriptions when individuals were engaging in maladaptive behaviors.<br>• Significant gaps in documentation when the nurses' notes stated, "will continue to monitor". The nurses consistently failed to state what would be monitored and the frequency of the monitoring.<br>• The method temperatures taken were rarely documented.<br>• 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.<br>• Lack of notification/referral to the Infection Control Preventionist Nurse when contagious disease outbreaks occurred.<br>• Lack of analysis of contributing problematic issues affecting changes in status.<br>• Lack of documentation through to resolution for acute changes in status.<br>• Inconsistent development and implementation of Acute Care Plans (ACPs) for acute changes in status.<br>• Annual and Quarterly Comprehensive Nursing Assessments were not revised to reflect significant changes in status or new problems until the next assessments were completed.<br>• Lack of consistently updating Health Maintenance Plans (HMPs) to reflect changes in status or new interventions. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • Lack of consistent documentation in the Integrated Progress Notes when HMPs and/or ACPs were initiated.<br>• Lack of adherence to Nursing Protocols.<br>• Late entries were frequently documented in the Integrated Progress Notes. However, the late entries were correctly documented.<br><br>An attempt was made to evaluate compliance with the Nursing Protocol: Seizure Management Guidelines for Individuals: #72, #86, #47, #118, #98, #19, and #60. However, the Facility's system for documenting seizure active was so fragmented it was not possible to adequately determine the degree of compliance with the Nursing Protocol: Seizure Management Guidelines. Seizure activity documentation was entered into CWS on a variety of reports. The reports included the Crystal Reports, Medical Observation Inquiry Reports, and Integrated Progress Notes. When cross checking various reports, inconsistencies were found between the different reports. Therefore, compliance with the Nursing Protocol: Seizure Management could not be determined. Considering the fragmentation of the seizure activity data it was questionable how this data could be linked together to get an accurate picture of individuals' seizure status, much less use the data for making clinical decisions. The Facility should ensure consistency in reporting seizure activity data into the Crystal Reports, Medical Observation Inquiry Reports, and the Integrated Progress Notes. Further, the Facility should evaluate the effectiveness of the seizure report system in making clinical decisions.<br><br>In an effort to improve services several new procedures/processes were put in place since the last compliance review, which included:<br>• In one of the units a dedicated room was set up and equipped as an exam room for the physicians. The physicians were provided a nurse for assistance and a clerk to maintain the Appointment System.<br>• Developed and implemented a process for using a Mini-Kardex in both units. The purpose of the Mini-Kardex was to have a quick reference for the nursing staff to use each day/shift, for each individual's care and management plan, that included schedules, assessments, treatments, procedures, labs, and other plans of care. The Mini-Kardexes were kept in nurses' office in binders and were updated as necessary. A review of the Mini-Kardexes showed the nurses were using them. Their use should help the nursing staff avoid overlooking individuals' daily plans of care.<br>• Developed and implemented a template for physician's orders for each individual. The template included allergies, adverse drug reactions, diet texture, crush or give medication whole, and other pertinent alerts. The templates were stored on the shared drive for the nurses to print when a new Physician's Order sheet was needed.<br>• Developed and implemented a process for lab requests. Both units maintain a book | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | with physician's orders lab tests and copies of the lab test requests, separated by month and year.<br>These new procedures/processes appeared promising to improve the quality of medical/health care services. The effectiveness of these newly implemented procedures/processes will be reviewed at the next compliance visit.<br><br><u>Availability of Pertinent Medical Records</u><br>As was found in past reviews, there was no improvement in the Integrated Progress Notes contained in the Client Work Station (CWS), which continued to make it difficult to tie clinical data together in a meaningful way to gain a clear and comprehensive picture of individuals' clinical status. This posed a barrier when integrating clinical data into a useful manner. While completing record reviews on the Integrated Progress Notes 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 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. The demographic information printed on the forms using the addressograph cards and machines were not readable. Either the addressograph cards were worn-out or the machines were out of ink.<br><br><u>Hospital Liaison Nurse Activities</u><br>At the time of the compliance visit, the NOO/Hospital Liaison position was vacant. Records were reviewed for Individuals: #19 and #26, who were recently hospitalized. It was positive to find some improvement in compliance with the Nursing Protocol: Hospitalization, Transfer, and Discharges. In the absence of the NOO/Hospital Liaison, the PNMT Nurse served in that capacity. The PNMT Nurse also completed the PNMT Post Hospital Nursing Assessment. The only exception to the protocol was the failure to find evidence that Acute Care Plans were established post-hospitalization to address Individuals #19 and #26s' acute change in status problem.<br><br><u>Infection Control Activities</u><br>The Infection Control Preventiontist, who was appointed at the last compliance review, was responsible for the Infection Control Program at the ICF-MR Facility, Mental Health Hospital, and Outpatient Clinic. She had begun making improvements in the Facility's Infection Control Program and maintained the existing program activities. An interview with the Infection Control Preventionists and review of documents found:<br>• It was positive to find that an Immunization Database had been developed and implemented that recorded each individual's past history and current immunization | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | status, as well as identified immunizations that were delinquent and/or when immunizations were due for updating. Through the use of this database the health care providers should be able to proactively keep individuals immunizations up to date.<br>• The previously developed and implemented Comprehensive Preventative Health Database was maintained and updated. This database not only tracked each individual's immunization status; it also provided the Facility's overall percentage of compliance for each required immunization. In addition, the database tracked preventative health follow-up requirements for Tuberculosis, Diabetes, Hypertension, Gastroesophageal Reflux (GERD), Cardiac, Infections, and Risk Ratings. The overall percentage of compliance of immunizations and preventive health follow-up was summarized year to date; the score was reported at 97% compliance. There was documented evidence that the data were tracked and analyzed monthly, and plans of correction were put in place for individuals who were not current with their immunizations and/or preventative health follow-up. However, there was no follow-up procedure or documentation to validate that when plans of correction were implemented that they carried out to resolution or that the plans were evaluated for effectiveness.<br>• There was documented evidence that the Infection Control Preventionist and other designated staff conducted quarterly environmental surveillance inspections in all individual areas. The surveillance primarily included walk though observation of the units and individual areas, checking on cleanliness, methods of disposal, methods of storage, individuals care, and infection control practices, including hand hygiene and use of standard precautions. The data was summarized quarterly and reported in the Departmental Performance Measures Reports. These quarterly reports were presented at the respective Safety/Risk Management/Infection Control Committee Meetings for review, discussion, and plans of correction were made when indicated. The recommendations from the committee for plans of correction were developed and implemented by the Infection Control Preventionist. These activities were further validated through a review of the Departmental Performance Measures Report Fiscal Year 2012, Third Quarter Report and Monthly Safety/Risk Management/Infection Control Committee Meetings, February 2012 through May 2012. However, there was no follow-up procedure or documentation to validate that when plans of correction were implemented that they carried through to resolution or that the plans were evaluated for effectiveness.<br>• The Infection Control Preventionist stated that she used the Pharmacy's Daily Report of Antimicrobial uses, as well as the 24 Hour Nursing Event Logs to conduct "real time" investigation of infections.<br>• The Monthly Infections Reports included total number of infections, percentage rate of overall infections, percentage rate of Healthcare-Associated Infections and listed | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | types of infections and reported all infections by type. Center for Communicable Disease criteria were used for calculating rate of Healthcare-Associated Infections. She also followed the criteria established by the Texas Department of Health Services for State Mental Health Hospitals to determine the percentage rate of Healthcare-Associated Infections and used this information to identify trends. She stated the percentage rate of Healthcare-Associated Infections was determined by an annual average percentage rate from all state Mental Health Hospitals. Currently, a percentage rate of Heath-Associated Infections of 11% or greater was considered a trend. This method of determining trend was unlike any other method used by the SSLC's. She stated that unless the infections met the Healthcare-Associated Infection definition of a monthly rate of 11% or greater, other infections were not tracked for trends. The feasibility of using this method for identifying trends at the ICF-MR Facility was of concern because individuals diagnosed with contagious infections/diseases at the Facility may not fit the Healthcare-Associated Infection definitions and/or rise to percentage rate of 11%, but nevertheless have the potential to spread to other individuals or require further investigation to prevent or minimize reoccurrence such a pneumonias of all type. Such infectious/contagious diseases were found and noted in the report below.<br>• A review of the Infection Control Surveillance Reports contained in the Safety/ Risk Management/Infection Control Committee Minutes for February 2012 through April 2012 (there were no reports provided to review for May 2012 through August 2012) showed the information below for the combined Units. Review of these data following the visit indicated possible inconsistencies, such as listing form 21-26 infections per month, but only identifying 21 infections treated. It is possible these possible inconsistencies could have been resolved through discussion, but the Monitoring Team did not identify them until thorough review was made of the report. The Facility should examine this information and ensure it is accurate, and provide clarification at the next compliance visit.<br>o January Infection Report for Second Quarter 2012:<br>▪ 29 infections for a 41% Infection Rate<br>▪ 7% SSLC Healthcare Associated Infections Rate: 4 pneumonias, 1 conjunctivitis, and 2 Urinary Tract Infections (UTIs)<br>▪ Types of Infections: 4 pneumonias; 5 cellulitis; 3 H-pylori; 2 UTIs; 3 abnormal x-rays; 1 pulmonary infiltrate; 1 sinusitis; 1 tinea pedis; 1 post circumcision; 1 abdominal wound; and 1 vomiting; 1 ileus: 1 conjunctivitis;1 sinusitis;1 mouth swelling post tooth extraction; 1 wound to right elbow; and 1 post cystoscopy treatment<br>o February Infection Report for Second Quarter 2012:<br>▪ 29 infections for a 41% Infection Rate<br>▪ 7% SSLC Healthcare Associated Infections Rate: 4 pneumonias, 1 conjunctivitis, and 2 Urinary Tract Infections (UTIs) | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | ▪ Types of Infections: were not reported<br>o March Infection Report for Third Quarter 2012:<br>▪ 26 infections for a 41% Infection Rate<br>▪ 11% SSLC Healthcare Associated Infections Rate: 17 (types of infections not included)<br>▪ Types of Infections: 4 asymptomatic bacteriuria (ABS); 2 lower respiratory infections; 2 H-Pylori; 2 nonspecific pneumonia; 2 cellulitis; 1 post tooth extraction; 1 sinusitis; 1 rhinitis; 1 cough; 1 bronchitis; 1 otitis;1 nasal drainage;1 pressure ulcer to upper thigh;1 abrasion to abdomen; 1 balanoposthitis;1 urinary frequency; 1 urinary retention; 1 UTI, and 1 post cystoscopy<br>o April Infection Report for Third Quarter 2012:<br>▪ 21 infections for a 31% Infection Rate<br>▪ 7% SSLC Healthcare Associated Infections Rate: 17 (types of infections not included)<br>▪ Types of Infections:<br>▪ 4 cellulitis; 4 urinary frequencies; 2 symptomatic urinary tract infection (SUTI); 2 pneumonias, probably aspiration; 1 lower respiratory infection (infiltrates); 1cough; 1 congestion; 1 redness to eyes; 1 rash to buttock; 1 ulcer to left foot;1 abscess to lower left eyelid; 1 wound to left wrist; and 1 post cystoscopy<br>• Of the 21 infections treated for various individuals at the Facility, five met the criteria for Healthcare-Associated Infections; pneumonia and lower respiratory infections had a higher incidence in La Paloma, while symptomatic and urinary frequencies had a higher incidence in El Paisano.<br>• It was positive to find that in the past three fiscal year quarters for 2012, the Facility reported no incidents of Methicillin-resistant Staphylococcus aureus (MRSA) or other multi-drug resistant organisms; including pseudomonas and clostridium difficile (C-diff). It was of concern that the infection data above, which were presented at the Safety/Risk Management/Infection Control Committee Meetings did not include in their minutes any discussions for interventions to prevent or minimize the reoccurrence or spread of potentially contagious infections/diseases reported. There was no system in place for reporting and tracking individuals who were determined to be carriers of various contagious organisms/diseases. The Infection Control Program should report, track, and monitor individuals identified as carriers for various contagious organisms/diseases.<br>• Of the 70 individuals, 97% were current with influenza vaccinations. Two individuals were admitted in June 2012 after the flu season.<br>• Of the 70 individuals, 100% were compliant with tuberculosis skin testing or chest x-rays. No tuberculosis converters were reported during annual testing in 2012. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • Of the employees, 93% were vaccinated with influenza vaccinations. Seven percent of the employees signed influenza vaccination declination forms.<br>• Of the individuals 50 years of age and older, 100% had received Zoster vaccinations.<br>• Of the employees, 100% were current with tuberculosis skin testing or questionnaires.<br>• Of the employees, 100% of the employees identified as high risk were vaccinated with the Hepatitis B series.<br>• The Facility reported all employees were current in annual refresher Infection Control training. Infection Control training continued to be provided in New Employee Orientation (NEO).<br>• At the last compliance review, the nail clippers were not found routinely sanitized and individually packaged. The Infection Control Program did not have a procedure for cleaning and storing nail clippers. Since then, a procedure had been developed and implemented. The Monitoring Team checked the nail clippers in both Units and found they were individually packaged and labeled with each individual's name. The nail clippers were sanitized at least weekly or more often when needed.<br>• The infection Control Preventionist maintained Antibiotic Susceptibility of Common Organisms Reports, attended the Pharmacy and Therapeutic Committee Meetings and shared the information with the Pharmacist and physicians. Refer to Provision M.6 for more information.<br><br>The infection Control Preventionist reported that the Nursing Protocol for Antibiotic Therapy was put in CWS as a reminder for the nurses to follow but it was not being followed consistently. She said she was not reviewing the Acute Care Plans (ACPs) appropriateness in managing infections and agreed this needed to be done. Refer to Provision M.3 for a review of individuals ACPs who had active infections at the time of the compliance review.<br><br><u>Skin Integrity Activities</u><br>The Nursing Department did not have a system in place to track skin breakdown/decubitus. Neither did they have a dedicated Skin Integrity Nurse. Formerly, the Physical and Nutritional Management (PNM) Committee reviewed skin integrity issues. According to the CNE, the review of skin integrity issues was discontinued by the PNM Committee due to lack of time. The lack of time by the PNM Committee does not absolve the Facility's responsibility for monitoring, reporting, tracking, analyzing, and trending skin breakdowns/decubitus ulcers/skin integrity issues. This is essential due to the Facility's At Risk Individuals Report for 2012, which indicated that 19 of 70 (27%) individuals had high and medium risk ratings for skin integrity issues, i.e., four of 19 (21%) individuals had high risk ratings and 15 of 19 (79%) individuals had medium risk ratings. The Monitoring Team requested the | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Nursing Department to identify individuals with active skin integrity issues, copies of their health care plans, physician orders related to the treatment of skin integrity issues, and printed copies of CWS Integrated Progress Notes validating treatment and nursing management. This information was provided, reviewed, and reported below.<br><br>Two individuals were reported to have active skin integrity issues at the time of the compliance review. Individual #47 was reported to have a stage II decubitus ulcer of the coccyx. Individual #126 was reported to have dermatitis (diaper rash) due to incontinence of bowel and bladder. The Health Management Plans (HMP) for these two individuals were copied from the stock care plans and were not individualized sufficiently to meet the individuals' specific health care needs related to their skin integrity issues. The physician order provided for Individual #47 was not included in the HMP, neither was it reviewed/revised on quarterly bases. There was documentation that the direct support staff were trained on the HMP. The same issues were found regarding Individual #126's HMP and physician orders. Copies of the CWS Integrated Progress Notes validating care of for these individuals were not provided as requested. The Facility needs to develop and implement a skin integrity system for monitoring, reporting, tracking, analyzing, and trending skin breakdowns/decubitus ulcers/skin integrity issues. Refer to Provision M.3 for additional information regarding HMPs and Acute Care Plans (ACPs).<br><br><u>Medical Emergency Response Activities</u><br>Since the last review the Facility had continued to make steady progress toward meeting the requirements of the Medical Emergency Response, Standard Operating Procedure, ICF-DD 100 18, Date Established: 9/23/10, Revised: 9/22/11. The Interim Vocational Manager was responsible for conducting, reporting, and tracking Mock Emergency Drills. He had made significant improvements to the Facility's Emergency Response System. Improvements included:<br>• A review of the required emergency equipment found that all required emergency equipment was present in the designated areas. The nursing staff brings the medication box to the scene for Mock Medical Drills and actual code events. The location of emergency equipment was clearly posted in the designated areas.<br>• Since the last compliance review, the Interim Vocational Manager had trained six Campus coordinators/program specialists on the Emergency Response Drill Instructor Competency Exam. This provided the Facility with additional drill instructors to conduct the Mock Medical Emergency Drills and to assist with performing Emergency Equipment Walkthrough Checklist.<br>• 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%. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • The Facility's Emergency Checklist Analysis Summary reported that the nursing staff had maintained the Medical Emergency Equipment Checklists, including Automated Defibrillators (AED) according to policy, as described in the table below: | |

| Month 2012 | La Paloma | El Paisano | Vocational Services |
|---|---|---|---|
| February | 100% | 93% | 100% |
| March | 100% | 0% | 100% |
| April | 100% | 0% | 100% |
| May | 97% | 97% | 100% |
| June | 100% | 100% | 100% |
| July | to be completed | to be completed | to be completed |

The Monitoring Team's review of the Medical Emergency Checklists, May 2012 and June 2012, found the AED and Emergency Bag Check Off Sheets were consistently checked daily in El Paisano and La Paloma, except in the Vocational Services area, which was not checked on weekends and holidays because this area was not in use during those days.

- The Mock Medical Emergency Drill Schedules were not made available for review. However, there was documented evidence that indicated that the results of the Mock Medical Emergency Drills and corrective actions were reviewed monthly at the Safety/Risk Management/Infection Control Committee Meeting Minutes. The results were also presented weekly at the Incident Management Review Team Meetings. The Interim Vocational Manager stated the drill outcomes were not tracked, analyzed, graphed, and reported to the Quality Enhancement Department. He said he would start reporting the drill information to the Quality Enhancement Department. This issue will be followed up at the next compliance review.
- A review of the completed Mock Emergency Drill Checklist February 2012 through July 2012 showed that the Facility continued to provide "on the spot" retraining. When staff were retrained "on the spot", but they were not successful after retraining, they were sent to CTD for refresher training. The nursing staff consistently participated in the drills. 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 were also checked to ensure they contained an adequate supply of oxygen. Unfortunately, the physicians did not participate in the drills, as was found at the last compliance review. The Facility should expect physicians to participate in the drills, unless there are justifiable reasons that they cannot participate. The Facility should conduct Mock Medical Emergency Drills using a variety of scenarios that have the potential to be life threatening, which are identified in the Emergency Response Policy.
- The Facility reported there were no staff delinquent in Basic Cardiopulmonary Resuscitation (CPR) and CPR for Healthcare Providers training.
- The procedure for executing the use of the cell phone for Mock Medical Emergency

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Drills and/or actual codes was in place.<br>• At the last compliance review, it was found that the nursing staff had not been trained on the revised Emergency Response Policy. The Nurse Educator stated that he would ensure that all nurses were trained on the Policy. A thorough review of the Nurses' Competency Training Database did not indicate that the nursing staff had been trained on the revised Emergency Response Policy.<br><br>The Facility should maintain the positive practices identified in the report and make improvements on the following practices:<br>• The Nursing Department should make every effort to secure additional nursing positions and continue to recruit and retain full time nursing staff.<br>• The Nursing Department should ensure that all Nursing Care Monitoring Tools are completed according to schedule, sent to the Quality Enhancement Department to enter into the Quality Enhancement Database, analyzed, and trended for compliance. For the tools falling below 90% (the criterion used by the Facility), a systemic CATW2 should be developed, implemented, and followed through to resolution.<br>• The Facility should ensure consistency in reporting seizure activity data into the Crystal Reports, Medical Observation Inquiry Reports, and the Integrated Progress Notes. Further, the Facility should evaluate the effectiveness of the seizure report system in making clinical decisions.<br>• The Infection Control Program should report, track, and monitor individuals identified as carriers for various contagious organisms/diseases.<br>• Develop and implement a system for tracking nurses' reporting of infections, to ensure "real time" investigations are conducted on all infections.<br>• Review all infection related ACPs for appropriateness and individualization to ensure they are sufficient to meet the individuals' specific needs. Review the ACPs to ensure they are consistent with the Antibiotic Therapy Protocol. Provide the nursing staff with technical assistance to improve quality of the ACPs to ensure they include all relevant infection control preventative measures/interventions.<br>• The Facility needs to develop and implement a skin integrity system for monitoring, reporting, tracking, analyzing, and trending skin breakdowns/decubitus ulcers/skin integrity issues.<br>• The Nurse Educator should ensure that all nurses are trained on the revised Emergency Response Policy and emergency equipment.<br>• The Facility should expect physicians to participate in the drills, unless there are justifiable reasons that they cannot not participate.<br>• The Facility should conduct Mock Medical Emergency Drills using a variety of scenarios that have the potential to be life threatening, which are identified in the Emergency Response Policy. | |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>M2</td><td>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.</td><td>Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>• Reviewed nursing assessments for timeliness of completion and authentication monthly.<br>• Completed Section M Monitoring Tool - Annual Nursing Assessment monthly.<br><br>From its self-assessment the Facility determined that:<br><br>• The Annual/Quarterly Nursing Assessments were audited for timeliness of completion and nursing authentication. The audit criteria included:
<table>
<tr><td>Individual #</td><td>Annual or quarterly assessment?</td><td>ofas annual nursing assessment completed 10 days prior to annual PSP review?</td><td>Was the quarterly nursing assessment completed within the month due for quarterly review?</td><td>Was the nursing assessment (annual and quarterly) authenticated (per signature) by RN completing assessment?</td></tr>
</table>
The results of the audits found:<br>• 02/29/2012 – 85% completed timely and authenticated.<br>• 03/31/2012 – 70% completed timely and authenticated.<br>• 04/30/2012 - 72% completed timely and authenticated.<br>• 05/31/2012 – to be completed retrospectively.<br>• 06/30/2012 – 100% completed timely and authenticated.<br>• 07/31/2012 – to be completed retrospectively.<br>• Section M Nursing Care: Annual Nursing Assessment Monitoring Tool audit results found:<br>• 02/29/2012 - no monitoring tools completed.<br>• 03/31/2012 - no monitoring tools completed.<br>• 04/30/2012 – one monitoring tool completed.<br>• 05/31/2012 – no monitoring tools completed.<br>• 06/30/2012 – three monitoring tools completed.<br><br>Based on the findings of the self-assessment, the Facility determined this Provision was not in substantial compliance because the activities either had not been completed in a timely manner or scores had not reached 90% for at least four consecutive months. Due to the recent turnover of Case Managers and the Quality Enhancement Nurse, the monitoring tools schedule has not been completed timely and analysis was not</td><td>Noncompliance</td></tr>
</table>

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | completed with the most current monitoring tools submitted to Quality Management.<br><br><u>Monitoring Team Findings</u><br>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 no significant improvement since the last compliance review toward achieving compliance with the requirements contained in this Provision.<br><br>The two most recent Admission and/or Annual, and Quarterly Comprehensive Nursing Assessments were reviewed for Individuals #5, #141, #29, #72, #119, #140, #51, and #126, who had multiple high and/or medium risk ratings: Of the eight individuals' Admission and/or Annual and Quarterly Comprehensive Nursing Assessments, 16 were reviewed. The findings included the following:<br>• Six of 16 (38%) Admission and/or Annual and Quarterly Comprehensive Nursing Assessments were completed according the Facility's ISP schedule.<br>• Sixteen of 16 (100%) Admission and/or Annual and Quarterly Comprehensive Nursing Assessments were completed by the RN Case Managers.<br>• Sixteen of 16 (100%) Admission and/or Annual and Quarterly Comprehensive Nursing Assessments had BRADEN skin integrity assessments completed.<br>• Sixteen of 16 (100%) Admission and/or Annual and Quarterly Comprehensive Nursing Assessments indicated the respective QDDP was notified.<br>• Zero of 16 (0%) Admission and/or Annual and Quarterly Comprehensive Nursing Assessments' Current Active Medical Diagnoses were consistent with those listed by the physicians on their Current Active Medical Diagnoses lists.<br>• Sections I through IX of the assessments found the following problematic issues:<br>o Consults were not consistently summarized.<br>o The effectiveness of medications were not consistently documented and summarized.<br>o The individuals with identified weight issues were not consistently summarized to reflect the status of progress or lack of progress regarding weight management plans.<br>o Pain assessments were not adequately assessed and described for individuals identified with chronic pain, e.g., location, onset, duration, quality, radiation, and common relief measures.<br>o Tertiary care was not consistently summarized to reflect the reason for tertiary care and outcome of the tertiary care.<br>o Immunization status for all required vaccines, particularly Measles Mumps, and Rubella (MMR) and Varicella were not consistently documented. The | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | immunization assessment section did not contain a block regarding Polio immunizations. None of the individuals' Polio vaccination status was included (recognizing that it is likely that no individuals residing at the Facility would meet criteria for adult vaccination, although histories of vaccination were often listed on the immunization record).<br>o Physical Assessments of systems related to high and medium risk ratings were not consistently summarized to indicate past history and current status.<br>• Sections X Nursing Problems/Diagnoses: Of the eight Individuals' reviewed, 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.<br><br>When individuals' risk levels change to high and/or medium risk ratings, the RN 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.<br><br>Since the last compliance review, no significant difference was noted in in the analyses and summaries of clinical data in Section XI Nursing Summary. The quality and format used for the nursing summaries varied from unit to unit and RN Case Manager to RN Case Manager. A review of the Section XI Nursing Summaries found the following:<br>• The Nursing Department continued to use the revised format for Section XI, Nursing Summary that included a variety of subsections:<br>o Review of Health Status from previous quarter/annual, to include any surgeries<br>o Health Risk Review<br>o Nursing problems/Diagnoses identified and read for the diagnoses<br>o Health Management Plans and Progress.<br>o Community Integration<br>• 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 | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | fragmented, making it even more difficult to discern the individuals' health status in relation to each of their problems.<br>• The nursing summaries did not clearly indicate the effectiveness of the HMPs or the need for revision or that they were revised. The impact the revised Integrated Health Care Plan will have on care planning is yet to be determined. This issue will be followed up at the next compliance review.<br>• Many of the nursing summaries continued to be written in capital letters, and had long run-on and fragmented statements, which made the content difficult to read and understand.<br>• It was further apparent that all levels of nursing management continued to lack a clear understanding as to how to analyze, summarize and present clinical data related to individuals' health problems to determine whether of or not there was progress related to their health problems. At the time of the review neither the Nurse Educator or the RN Case Managers, or other RNs, had received the mandatory Physical Assessment and Documentation Class. According to the Nurse Educator the Physical Assessment and Documentation Class was scheduled for some time in September 2012. This class should improve the RNs' physical assessment skills and knowledge and improve the quality of the all nursing assessments and documentation.<br>• As was found at the last compliance review, the Admission Nursing Assessment Form had not been adopted and implemented.<br><br>A review of Nursing Discharge Summaries for Community Living Discharge Planning for Individuals: #115, #145, #121, #13, and #80 found: As was identified at the last review the Nursing Department had not adopted, implemented, and trained the RN Case Managers on the DADS Nursing Discharge Summary Form, date 11/7/11. At the last review this form was discussed with the CNE and Nurse Educator, and was reviewed with the RN Case Managers who were employed at that time. The RN Case Managers continued to use the Comprehensive Nursing Assessment Form to complete the summaries for Community Living Discharge Planning. Consequently, none of five (0%) Comprehensive Nursing Assessments adequately identified the nursing care planning needs sufficient to assist individuals' successfully transition into community living. The Nursing Discharge Summaries were expected to include the following information:<br>• Special Instructions: Medication techniques (likes/dislikes/crushed medications, and other such information), triggers/signs/symptoms of illness/behaviors (how I communicate when I don't feel well or what makes me angry, and other such information), special techniques that aids in individuals cooperation, as well as a other pertinent information (i.e., special behaviors and what they mean, how I communicate, signs and symptoms of pain, and other such information).<br>• Attachment needed to include: | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • Current Medication List<br>• Current Immunization Record<br>• Last MOSES/DISCUS<br>• Integrated Risk Rating Form and Risk Action Plans<br>• Nursing Care Plans/Staff Instruction Sheets<br><br>In order for improvements to be made in the Annual, Quarterly Comprehensive Nursing Assessments, as required in this Provision of the Settlement Agreement, the Nursing Department should ensure:<br>• The RN Case Managers complete an addendum to the Annual/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 health care plans for changes in status.<br>• The RN Nurse Managers summarize each nursing problem/diagnosis separately for clarity.<br>• The RN Case Managers avoid writing nursing summaries in capital letters with long run-on statements.<br>• 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 RN Case Managers.<br>• The RN Care Managers attend the mandatory Physical Assessment and Documentation Class.<br>• 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. | Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>• The RN Case Managers were monitoring quarterly and annual reviews to determine if interventions had been addressed promptly, implemented, and were effectively utilizing the Section M-Annual Nursing Assessment Monitoring Tool.<br>• Training was provided to the nursing staff on Aspiration Pneumonia Enteral Nutritional (APEN) evaluations.<br>• Reviewed a number of completed APENs.<br><br>From its self-assessment the Facility determined that:<br>• A review of the RN Case Managers' Annual/Quarterly Nursing Assessments found:<br>• 02/29/2012 – 85% were completed timely and authenticated.<br>• 03/31/2012 – 70% were completed timely and authenticated. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | Nursing interventions shall be implemented promptly after they are developed or revised. | • 04/30/2012 - 72% were completed timely and authenticated.<br>• 05/31/2012 – to be were completed retrospectively.<br>• 06/30/2012 – 100% were completed timely and authenticated.<br>• 07/31/2012 – to be completed retrospectively.<br>• Currently of the two new RN Case Managers, only one had been trained on the nursing section for APEN Evaluations.<br>• Three APENs had been completed based on high risk individuals due to enteral feedings. There was one APEN pending.<br><br>Based on the findings of the self-assessment, the Facility determined this Provision was not in substantial compliance because the outcomes noted in the monitoring data above were not addressed. The APEN Evaluations had only recently been implemented and there was not enough data to support compliance.<br><br><u>Monitoring Team Findings</u><br>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.<br><br>As found in past reviews, a review of eight 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 #51, #126, #141, #29, #119, #72, #140, #29, and #5 found no improvement since the last compliance review in the quality and substance of the HMPs and ACPs:<br><br>A total of 46 HMPs were reviewed that indicated:<br>• Twenty five of 46 (54%) had adequate baseline data stated for the identified health problems.<br>• Thirty one of 46 (67%) had adequate goals stated to measure the desired outcome for the identified HMPs.<br>• Zero of 46 (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 individuals' specific needs. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • Zero of 46 (0%) HMPs were developed in collaboration with other relevant disciplines, with the exception for occasionally referring to other disciplines, e.g., Physical Nutritional Management Plans (PNMPs) and/or (Personal Behavior Support Plans (PBSPs).<br>• Zero of 46 (0%) HMPs included proactive/preventative measures to reduce and/or eliminate risk indicators/problems.<br>• Zero of 46 (0%) specified the frequency the interventions were to be carried out, by whom, and where the interventions were to be documented.<br>• Zero of 46 (0%) contained documentation in the Nursing Integrated Notes that the HMP interventions were carried out as described.<br>• Thirty nine HMPs were due to be reviewed/revised at the time of Annual and/or Quarterly Comprehensive Nursing Assessments or when health status changed. Zero of 39 (0%) were reviewed at the time of the Annual and/or Quarterly Comprehensive Nursing Assessments. None were revised.<br>• Forty two of 46 (91%) HMPs contained documentation that the direct support professionals were trained and had special instruction sheets developed for the Me Books.<br>• Two of eight (25%) individuals' high and/or medium risk ratings that required nursing interventions had HMPs developed for all identified risk ratings. For example:<br>o Frequently individuals who had complex medical/health conditions had generic HMPs for Developmental Disabilities or Ineffective Health Maintenance. These plans were designed for routine care. They were too general and nonspecific to address complex medical needs for individuals' with high and/or medium risks ratings or who have active medical problems that require nursing interventions and should not be used for these individuals.<br>o A review of the 10 most recently completed HMPs showed no improvement from those reviewed above.<br>With the recently revised Integrated Health Care Planning Process it has yet to be determined the effectiveness of the plans. Their effectiveness will be reviewed at the next compliance visit.<br><br>A review of Individuals #67, #2, #26, and #75 who had active ACPs, found no improvement from the past reviews:<br>• Zero of four (0%) had adequate baseline data stated for the identified health problems that lead to the necessity for ACPs.<br>• Two of four (50%) had adequate goals stated to measure the desired outcomes for the identified ACPs.<br>• Zero of four (0%) ACPs were individualized sufficiently to meet the individuals' | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | 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.<br>• Zero of four (0%) interventions described in the ACPs were consistent with the related Nursing Protocols and/or specific physician orders requiring nursing interventions.<br>• Zero of four (0%) ACPs contained documentation in the Nursing Integrated Notes that the ACP interventions were carried out as described or that the related Nursing Protocol were followed through to resolution. Templates were entered into CWS as a reminder for the nurses to follow for all Nursing Protocol. However, the Nursing Protocol templates were not consistently, if ever, used to ensure the related Nursing Protocols were followed and documented.<br>• Zero of four (0%) ACPs indicated they were developed in collaboration with other relevant disciplines.<br>• Zero of four (0%) ACPs included proactive/preventative measures to reduce and/or eliminate risk indicators/problems.<br>• Zero of four (0%) ACPs specified the frequency the interventions were to be carried out, by whom, and where the interventions were to be documented.<br><br>In order for improvements to be made, as required in this provision of the Settlement Agreement, the Nursing Department should ensure:<br>• Integrated Health Care Plans (IHCPs) address all high and/or medium risk indicators and active problems that require nursing interventions.<br>• IHCPs are individualized to meet individuals' specific health care needs in relation to their identified risks and/or active medical problems.<br>• IHCPs are reviewed and/or revised at the time of the quarterly/annual nursing assessment or when there was a change in health status.<br>• ACPs and IHCPs include proactive/preventative measures to reduce and/or eliminate risk indicators/problems.<br>• ACPs and IHCPs contain integrated interventions in collaboration with other relevant disciplines, as required in Sections G and F of the Settlement Agreement.<br>• ACPs and IHCPs 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.<br>• All Nursing Protocols incorporated into the ACPs and followed through to resolution. | |
| M4 | Within twelve months of the Effective Date hereof, the Facility | Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served. | • Reviewed training compliance for the following policies and procedures:<br>o Emergency Equipment<br>o Medication Variances<br>o Documentation<br>o Dysphagia/positioning<br>o SSLC Nursing Protocol cards<br>o Hospital Transfers and Discharges<br>o Policy manual revision<br>o Nail Clipper disinfection process<br>o Sharp container safety<br>o Adult Immunization schedule EC 402-02 Infection Control Surveillance log weekly<br>o Adverse Drug Reaction<br>o Injury reports on appropriate episode<br>o CWS Immunization record<br>• Reviewed training and competency of the newly hired Nurse Educator.<br><br>From its self-assessment the Facility determined the following:<br>• Policy Training Compliance Results:<br>o 03/2012 – 47.2% completion rate.<br>o 04/2012 – 61.9% completion rate.<br>o 05/2012 – 95.2% completion rate.<br>o 06/2012 – 71.3% completion rate.<br>• Newly hired Nurse Educator completed Phase 2 of the PiCert on 07/31/2012.<br><br>Based on the findings of the self-assessment, the Facility determined that this Provision was not in substantial compliance because additional monitoring in the area of nursing compliance related to training was needed and not all training had been completed. Due to the 45 % of turnover rate with nursing staff and the Nurse Educator also serving in the in Unit Nurse Manager role, training compliance was in process.<br><br><u>Monitoring Team Findings</u><br>The Facility's Section M Self-Assessment stated they were not in compliance with this provision and the Monitoring Team concurs. Though review of Section M Self-Assessment, Section M Presentation Book, staff interviews and review of documents, there was evidence that the Nursing Department had made minimal progress toward achieving compliance in the various requirements contained in this provision. The lack of progress was reported in the Self-Assessment due to 45% turnover of nursing staff, particularly with the nursing administrative and management staff. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | The Nursing Department reported there had been no new policies implemented since the last compliance review. All 18 Nursing Protocols were implemented and the nursing staff trained on the protocols in February 2012. At the time of the compliance review, due to the high turnover of the nursing staff the Nurse Educator was also filling in as the NOO, Unit Nurse Manager, and at times a direct nursing staff. Therefore, the ability for the Nurse Educator to keep up with all the nursing training requirements had been difficult to accomplish. It is essential that all nursing staff consistently receive 100% of the required Nursing Competency-based Training in order to sufficiently meet individuals' health care needs.<br><br>Since the last compliance review, the Nurse Educator had developed and implemented a Monthly Nurse Competencies Calendar. The Nursing Training Tracking Database had maintained that provided comprehensive information regarding training activities. The database included the 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.<br><br>A review of the Monthly Nursing Training Tracking Database showed the percentage of nurses trained monthly on the required competency-based training:<br>• March 2012 – 90%<br>• April – 2012 – 92%<br>• May 2012 – 100%<br>• June 2012 – 82%<br>There were no reports for July 2012.<br><br>There was a wide disparity in the percentages of training compliance results reported in the Self-Assessment as opposed to the Nursing Training Tracking Database. The Nursing Department and Facility should re-evaluate the wide disparity in the two training data reports. This disparity renders the data unreliable for the purpose of determining progress toward compliance with this provision. It is essential that training data are accurate and all nurses receive 100% of the required nursing competencies.<br><br>The Nurse Competency Process indicated that CATW2s would be developed and implemented for failure of nurses to comply with the required training. There was documented evidence that the Nurse Educator implemented CATW2 for identified training deficiencies. After the nursing staff were trained on the nursing protocol cards, the Nurse Educator monitored 10% at two, five, and nine weeks after the training for compliance with the nursing protocols. The Nurse Educator developed and implemented CATW2s for March 2012, April 2012, and May 2012 all of which indicated that CNE was | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | informed that the nursing staff were noncompliant with following the nursing protocols. There was no documentation provided that showed the CNE had taken corrective action with the nursing staff's for non-compliance with the nursing protocols. The Monitoring Team's review of individuals' records in the other provisions rarely found evidence that the nursing staff were translating the nursing protocols 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.<br><br>It was positive to find, as was recommended at the last compliance review, arrangements were made for the incumbent nursing staff to receive dysphagia training provided in New Employee Orientation by the Speech Language Pathologist. Signed Training Rosters on 6/28/12 validated the nursing staff had received training in the NEO-Speech Training for: Dysphagia; Aspiration/Choking; Dysphagia Texture; Thickening Liquids Demonstration; Communication; Hearing Aids; AAC Devises; and AAC Device Demonstration. However, the percentage of nursing staff that were trained was not analyzed and summarized. It is essential that the Nursing Department ensure that 100% of nursing staff receive this basic dysphagia training. In addition, the Nursing Department should collaborate with the Habilitation Therapist to include the recently developed and implemented State Office Medication Administration Training for Dysphagia and Physical and Nutritional Management to ensure safe medication administration practices.<br><br>The Nurse Educator attended the Nurse Educator Meeting in Corpus Christi May 21 through 23, 2012. He stated that the State Mandated Physical Assessment and Documentation Class for the Nurse Educator and RN would be taught in September 2012. This is a much needed class for all RNs, particularly for the Nurse Educator and RN Case Managers to enhance their knowledge, skills, and competency in assessing individuals and planning for their care.<br><br>The Nurse Educator stated the new RN Case Managers had not received formalized competency-based training on MOSES and DISCUS. He was in the process of attempting to locate a qualified instructor to train the RN Case Managers. It is essential that the RN Case Managers receive competency-based training on MOSES and DISCUS because it is an integral part of their job function. This issue will be followed up at the next compliance visit.<br><br>In order for this Provision to meet compliance, not only must the State and Facility Nursing Policies, Procedures, Processes, and Protocols be established, implemented, and the nursing staff trained; they must be demonstrated through actual clinical practice sufficient to address the health status of individuals served. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Although this Provision was not found in substantial compliance, the Nursing Department should maintain the positive practices identified in the report and make improvements on the following practices:<br>• Ensure that all nurses consistently receive 100% of required nursing training and training records are accurately reported in the Monthly Nursing Training Tracking Database.<br>• Ensure that the nursing staff follow all Nursing Protocols.<br>• Collaborate with the Habilitation Therapist to include the recently developed and implemented State Office Medication Administration Training for Dysphagia and Physical and Nutritional Management to ensure safe medication administration practices. | |
| 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. | Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment:<br>• Implemented At Risk Individual Monitoring Process to determine if risk ratings and identification of clinical indicators of risk were supported by the At Risk Guidelines.<br><br>From its self-assessment the Facility determined that:<br>1. Risk Rating Assessments were completed on 100% of individuals, but the process was evolving. The Risk Rating Assessment Monitoring Tools were completed on two individuals with the following scores:<br>o 10/2011 = 17% compliance.<br>o 01/2012 = 27% compliance.<br><br>Based on the findings of the self-assessment, the Facility determined that this Provision was not in substantial compliance because this process was recently implemented and there was inconsistent and insufficient data to support compliance and sustainability.<br><br><u>Monitoring Team Findings</u><br>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 this provision.<br><br>In May 2012, the RN Case Managers and other relevant Facility's staff received training on the revised Integrated Risk Rating Form and Integrated Health Care Plan. The Facility had adopted and implemented a revised format for completing the Integrated Risk Rating Form. A review of 11 individuals' most recently completed Integrated Risk Rating and accompanying health care plans found four of 11 (36%) were completed on the | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | revised Integrated Risk Rating Forms with Integrated Health Care Plans.<br><br>The 11 recently completed Integrated Risk Rating Forms, Integrated Health Care Plan and/or Risk Action Plans were reviewed for Individuals #1, #3, #27, #66, #8, #96, #23, #140, #126, #75, and #145. The results of the review found the following trends, which show little, if any, improvement from the last compliance review:<br>• The quality of the Integrated Risk Ratings and Integrated Health Care Plans and/or 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, particularly in the four risk ratings completed using the revised Integrated Risk Rating Forms, there was a need for continued improvement in both the risk ratings and care plans.<br>• The objectives for the Risk Action Plans were not consistently adequate to functionally measure the efficacy of the plans.<br>• Clinical indicators to be monitored and the frequency were not consistently included or were not adequate to assess progress or lack of progress.<br>• The risk ratings did not consistently include clinical data from all relevant disciplines.<br>• The plans failed to consistently include preventative interventions to reduce or eliminate the risk levels.<br>• The plans did not consistently include action steps for all relevant disciplines, specifically related to nursing services.<br>• The plans were not consistently integrated into the ISPs.<br>• The actual date the plans were implemented could not be readily discerned, although they contained implementation dates.<br><br>According to the State Office Nurse Practitioner Consultant, the nursing Health Management Plans would be replaced with the Integrated Health Care Plan. It is yet to be determined the impact this will have on nursing services as part of revised Integrated Health Care Planning process. As was found at the last review, the other disciplines were not putting their assessment information into CWS timely, at least 10 days prior to the ISPs, for the RN Case Managers to review and prepare the drafts for the Integrated Risk Ratings for the IDTs to review at ISP meeting. This may be a contributing factor for the inadequacy of the clinical data rationale of the various risk ratings. It was of further concern with the revised Integrated Risk Rating process, that the RN Case Managers remained responsible for developing the drafts. Developing the draft takes considerable time to prepare; the length of time is further increased when the other disciplines do not make their risk assessments available timely. If the RN Case Managers have to review all of the other disciplines clinical data, some of the data may be overlooked or not fully appreciated because the data reviewed may not be within the their area of expertise. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | The RN Case Managers had caseloads of 35 individuals; with all the other responsibilities inherent in their job responsibilities, it is questionable, even with the highest degree of motivation and dedication, that they will be able to adequately manage a caseload of this size. The Facility and State should give serious reconsideration of eliminating the two RN Case Manager positions if individuals are to receive nursing care sufficient to meet their health care needs and to protect them from harm.<br><br>When reviewing a sample of the Aspiration Trigger Data Sheets with one of the RN Case Managers, it was of concern that the RN Case Manager thought the Monitoring Team was referring to the Aspiration Pneumonia Enteral/Nutrition Evaluation. The differences were explained between the Aspiration Trigger Data Sheets and the Aspiration Pneumonia Enteral/Nutrition Evaluation. The RN Case Manager stated she wondered what the Aspiration Trigger Data Sheets were because there were stacks in her office but didn't know what to do with them. It was serious concern that the RN Case Manager lacked an understanding of these critical documents, since they are a vital part of her job responsibility. When the RN Case Manager was asked if she was aware of the At Risk Individual Policy and associated attachments, it was apparent she had not received training on this Policy and the associated attachments. The CNE provided the RN Managers and Nurse Educator with copies of the At Risk Individual Policy.<br><br>A review of 52 Aspiration Trigger Data Sheets and Integrated Progress Notes when triggers were identified, March 1, 2012 through August 26, 2012, for Individuals #29, #47, #126, #72, #51, #98, #143, #140, #33, and #97, and #5 found:<br>• Three of 52 (6%) sheets had individualized triggers identified.<br>• Thirty five of 52 (67%) sheets were filled out for all triggers on all shifts.<br>• Eighteen of 52 (35%) sheets were initialed by the nursing staff daily on the 6-2 shifts.<br>• Twenty five of 52 (48%) sheets were initialed by the nursing staff daily on the 2-10 shifts.<br>• Forty two of 52 (81%) sheets were initialed by the nursing staff daily on the 10-6 shifts.<br>• Zero of 52 (0%) sheets were initialed, at least daily Monday through Friday, by the RN Case Managers as required. This was no doubt related to the fact that the RN Case Managers were not trained to check the Aspiration Trigger Data Sheet for compliance.<br>• Individuals #97 had high risk ratings for aspiration and dysphagia but did not have an Aspiration Trigger Data Sheet. Individual #5 had medium risk ratings for aspiration and dysphagia but did not have an Aspiration Trigger Data Sheet. Based on these individuals' risk ratings for aspiration and dysphagia they should be | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | monitored with Aspiration Trigger Data Sheets.<br>• Four of 10 (40%) individuals whose sheets were reviewed had one or more incidents of triggers reported during the period reviewed. Integrated Progress Notes were copied from CWS to verify whether the nursing staff were notified of the triggers and assessed those individuals for potential aspiration. A review of the trigger related notes found that the triggers were either not assessed by the nursing staff or if assessed, the assessments and follow-ups were inadequate to assess for evident of aspiration. The Vomiting Protocol was not followed for these Individuals: #47, #140, #29, and #51. For example:<br>o Individual #52 had a trigger recorded on 8/15/12 but Integrated Progress Notes were not provided to review to validate that the nursing staff follow-up with an assessment for aspiration.<br>o Individual #29 had triggers recorded on 5/8 and 5/9/12, 7/3/12, and 8/15/12. Integrated Progress Notes were only provided for 7/3/12, which stated that direct support professionals reported Individual #29 had swallow a small paper and began to cough. The nurse documented that he was in no distress and had no signs of aspiration. However, no vital signs, oxygen saturation levels or lung sounds were assessed by the nurse to rule out aspiration. The incident was considered behavioral. There were no further notes provided for review regarding follow-up of nursing assessments of the incident, nor was there documentation of notification of the behavioral or PNMT staff.<br>o Individual #140 had triggers recorded on 6/11/12. Integrated Progress Notes were provided for 6/11/12 which stated the individual was eating crushed chips when she began coughing and spit up some undigested food. Vital signs, oxygen saturation and lung sounds were assessed. No distress was noted. There were no further notes provided to review regarding follow-up of nursing assessments or that the PNMT staff was notified of the incident.<br>o Individual #47 had triggers recorded on 5/24 and 31/12, 6/9, 13, 15, 16, 17, and 27/12. There was no documentation for the trigger incident on 5/24/12. Individual #47 had numerous episode of vomiting documented in the Integrated Progress Notes. The nurses consistently failed to follow the Vomiting Protocol. Individual #47 was rated at high risk for constipation/bowel obstruction. Due to the Facility's inadequate monitoring of individuals bowel elimination patterns it plausible to question if he had a fecal impaction. There was no documentation regarding his elimination patterns or checks for fecal impaction. For example: On 5/31/12, the nurse documented that Individual #47 vomited a small amount of white phlegm. Vital signs and lung sounds were assessed. Oxygen saturation level was not assessed. There were no further notes provided to review regarding follow-up of nursing assessments. On 6/9/12 at 12:55 a.m., the nurse documented Individual #47 vomited twice moderate amounts of gastric contents with phlegm. Vital signs were assessed but oxygen saturations and | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | lung sounds were not assessed due to his uncooperativeness. The physician was notified and gave orders to withhold feedings if residuals were over 100 cc, to aspirate with syringe and discard gastric contents of 100cc, chest x-ray, and vital signs every shift discontinue nebulizer treatments, and maintain positioning at 90 degrees upright. On 6/9/12 at 1: 29 p.m., the nurse documented that Individual #47 vomited a moderate amount of whitish emesis. Vital signs were taken but oxygen saturation level and lung sounds were not assessed. Residual content of 100ccs was aspirated. It was documented that he was cleaned up and placed in bed with the head of the bed elevated at a 45 degree angle. This was in conflict with the physician's orders to keep him in a 90 degree upright position at all times. The physician was notified of the vomiting episode. There were no further physician's orders. Individual #47 was not assessed again until 5:07 p.m. on 6/9/12, when the nurse documented 82ccs of greenish residual. The physician was notified of the emesis and gave orders to continue the feeding. On 6/9/12 at 5:15 p.m. the nurse documented that Individual #47 coughed twice. Vital signs and oxygen saturation levels and lungs were assessed. No distress was noted. The nurse documented she would notify the physician. There was no further follow-up documented. On 6/27/12 at 5:27 p.m., while Individual #47 was being prepped for a colonoscopy, he vomited after the second dose of 12 ounces of Golytely. No vital sign, oxygen saturation level, or lung sounds were documented as having been assessed. The physician was notified who ordered to give Fleets enemas, if no results obtain a KUB.<br><br>On 6/27/12 at 9:05 p.m., the nurse documented that two Fleets enemas were given. Both enemas yielded results of watery yellow stools. There was no documentation that Individual #47 was checked for an impaction. The last nursing note on 6/28/12 at 5:27 a.m., documented that vital signs and oxygen saturation level was assessed but no lung sounds were assessed. The nurse documented there was no nausea or vomiting during the night and that he tolerated liquid intake. There were no further notes provided to review regarding follow-up nursing assessments.<br><br>When the CNE was ask about the training the Nurse Case Managers had received specific to their case management responsibilities, she assured the Monitoring Team the RN Case Managers had a completed a competency-based check-off sheet to show their training. The Monitoring Team requested the CNE provide copies of the RN Case Managers' functional job description and competency-based check-off sheet of their job training. She agreed to provide these copies but they were not received for review. The two recently hired RN Case Managers reported they had case management experience previous to employment at the Facility. One was a RN case manager for a home health agency and the other a RN case manager in a long term facility. They both appeared | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | motivated and dedicated to provide excellent nursing services to individuals. However, staff perform proportionally to how well they are trained and supported. Staff who do not receive adequate training and support to do their job often become disenchanted and leave their jobs. It is essential that the Nursing Department invest in ensuring these new RN Case Managers are adequately trained and supported if they are to continue employment. The 45% turnover rate in nursing staff should be of serious concern to the Nursing Department and every effort should be made to ensure these experienced, motivated, and dedicated RN Case Managers are retained.<br><br>Although this Provision was not found in substantial compliance, the Facility should maintain the positive practices identified in the report and make improvements in the following practices:<br>• The Nursing Department should ensure the new RN Case Managers are adequately trained and supported in their roles and responsibilities related to the Integrated Risk Rating and Health Care Plan process.<br>• The Nursing Department should ensure that the shift nurses are adequately competency-based trained on checking and initialing the Aspiration Trigger Data and following up with nursing assessment on individuals reported to have triggers. The Nursing Department should ensure that the RN Case Managers, or other RNs in their absence, review the Aspiration Trigger Data Sheet daily, at least Monday through Friday.<br>• The Facility Program Director should ensure that the direct support professional staff are adequately competency-based trained on completing the Aspiration Trigger Data Sheets on individuals who require aspiration monitoring and that they are monitored by their respective supervisor to ensure they adhere to the requirement, as well as notification of the nursing staff when individuals develop triggers.<br>• The Facility and State should give serious reconsideration of the decision to eliminate the two RN Case Manager positions if individuals are to receive nursing care sufficient to meet their health care needs and to protect them from harm.<br>• The Facility should ensure that the other disciplines consistently and timely provide the RN Case Managers 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.<br>• The State Office Nursing Coordinator and/or Nurse Practitioner Consultant should continue to provide the Nursing Department with technical assistance in defining and clarifying the RN Case Managers' role and responsibilities for the revised Integrated Risk Rating Form and Integrated Health Care Plan Processes. | |
| M6 | Commencing within six months of the Effective Date hereof and with | Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: | Noncompliance |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.</td><td>
<ul>
<li>Reviewed medication error policy and procedure to ensure compliance with Department of Aging and Disability (DADS) State Office policy.</li>
<li>Reviewed tracking and trending reports generated by the Medication Management Workgroup and Pharmacy and Therapeutics Committee.</li>
<li>Reviewed systems currently in place to reduce medication errors.</li>
<li>Reviewed nurses' compliance with Medication Administration Observations completed by the Nurse Educator monthly per schedule.</li>
</ul>
From its self-assessment the Facility determined that:
<ul>
<li>The Medication Error Policy was in place and complied with DADS State Office expectations.</li>
<li>Medication errors were showing downward trend.</li>
</ul>
Number of Medication Errors for the Third Quarter:
<table>
<tr><td>Total Errors</td><td>6</td></tr>
<tr><td>La Paloma</td><td>1</td></tr>
<tr><td>El Paisano</td><td>5</td></tr>
<tr><td>Shift with highest errors:</td><td>2-10 shift (no change since last quarter)</td></tr>
<tr><td>Day of the Week</td><td>Sunday at 49%</td></tr>
<tr><td>Severity Index Classification of Errors</td><td></td></tr>
<tr><td>A</td><td>1</td></tr>
<tr><td>B</td><td>1</td></tr>
<tr><td>C</td><td>1</td></tr>
<tr><td>D-I</td><td>1 (D)</td></tr>
<tr><td>Highest Node of Error Identified</td><td>administering</td></tr>
<tr><td>Highest Type of errors identified</td><td>None, all equal</td></tr>
<tr><td>Highest Cause of errors Identified</td><td>None, all equal</td></tr>
<tr><td>Highest Contributing Factor Identified</td><td>Distraction</td></tr>
<tr><td>Highest Medication involved</td><td>None, all equal</td></tr>
<tr><td>Highest staff identified as initiating error</td><td>LVN</td></tr>
</table>
<ul>
<li>Based on the Medication Error Reports, medication rooms in both homes had been modified to include an alcove to provide privacy and to decrease distraction for the nursing staff during medication administration. Medication errors continued to be reviewed monthly at the Medication Management Workgroup meetings and were analyzed quarterly at the Pharmacy and Therapeutics Committee meetings.</li>
<li>The results of Medication Administration Observations were reported as follows:</li>
</ul>
<table>
<tr><td>02/2012</td><td>Instructed nurses not to crush medications that were not</td></tr>
</table>
</td><td></td></tr>
</table>

| # | Provision | Assessment of Status | | Compliance |
|---|---|---|---|---|
| | | | on the do not crush list and to notify MD and Pharmacy.<br><br>Sent a CAP to NOO and UNM. A class at the nurses meeting was given on the 03/01/2012 on the do not crush list. | |
| | | **03/2012** | Medications on the do not crush list were not crushed by the Nurses. Instructed Nurses on hand washing after every fifth individual, then may use hand gel unless hands were visibly dirty.<br><br>Temperatures should be monitored and entered to the worksheet. | |
| | | **05/2012** | The LVN scored 87% on the Medication Observation Audit. The nurse was scheduled for another Medication Observation Audit and was instructed on Medication Administration. | |
| | | **06/2012** | Instructed Nurses on the PMAP to communicate to individuals on their PMAP. For example, inform the individuals if they were to receive crushed medications with apple sauce or other appropriate food stuff. | |
| | | Based on the medication administration observation schedule, 100% of nursing staff had been observed for medication administration.<br><br>Based on the findings of the self-assessment, the Facility determined that this Provision was not in substantial compliance because reporting and administration of medication expectations were not met. Efforts continued to comply with reporting medication variances events.<br><br><u>Monitoring Team Findings</u><br>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 some improvements toward achieving compliance in this provision.<br><br>A review of the medication administration and medication variance policies submitted by the Nursing Department, found that they had adopted and implemented the DADS Medication Administration Guidelines, dated February 2011, and the draft policy for Medication Variances/Incidents. A cross-check with the final DADS Medication Variances Policy, 053 found variation between the draft DADS Medication Variances/Incidents and the final DADS Medication Variance, Policy Number: 053, | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Effective: 9/23/2011. The Nursing Department should adopt and localize the final DADS Medication Variance, Policy Number: 053 to ensure compliance with the policy.<br><br>The Facility had a combined Medication Management Workgroup with the other components of this facility, which was chaired by the Pharmacist Consultant. The Facility did not have a monthly Medication Variance Committee dedicated specifically for the ICF-MR Facility and chaired by the CNE or designee, as required by the Medication Variance Policy, 053. Only the Medication Management Workgroup Meeting Minutes for 5/29/12 was made available for review along with a copy of the agenda for 6/26/12. Therefore, it could not be determined if the June meeting actually occurred. The Medication Administration Workgroup Minutes reported the number of medication variances for March, April, and May 2012 for Mental Health Hospital, ICF-MR Facility, Outpatient Pharmacy and Inpatient Pharmacy. The Pharmacist Consultant asked why there were no medication variances reported for April and May 2012, and added this needed to be addressed. The Facility Pharmacist stated that all the documentation for medication errors was there, but did not have time to enter them into the system within the five day dateline. Except for this concern, there was no further discussion of the medication variances, nor was there a plan of correction for the medication variances addressed in the meeting.<br><br>A review of the Pharmacy and Therapeutic Sub-Committee Meeting Minutes, 6/13/12, reported the Medication Error Report Trend Analysis for the third quarter 2012. This was a combined meeting with the other areas. The ICF-MR Facility had 7 errors reported, while the total of 60 errors was reported for all areas. The only corrective action to the summary was to correct page four the Corrective Action Summary but failed to indicate what needed correcting. Otherwise, there was no further discussion of the medication errors/variances reported in the minutes.<br><br>The Monitoring Team attended the Pharmacy and Therapeutic Sub-Committee Meeting, 8/29/12. The Sub-Committee reviewed and discussed the four quarter 2012 Medication Variances. The medication variance data showed a significant increase in Inpatient Pharmacy medication variances due to realizing they were not reporting some variances. The Pharmacy Department Medication Fill Variances were reported separately for the ICF-MR Facility's unit as reported in the chart below:<br><br>El Paisano / La Paloma<br>Type / July 2012 / August 2012 / July 2012 / August 2012<br>Wrong Drug / 2 / 1 / 2 / 0<br>Wrong / 3 / 0 / 0 / 1 | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Strength | | | | |
| Wrong Dosage | 3 | 1 | 0 | 0 |
| Wrong Quantity | 12 | 1 | 7 | 1 |
| Missing Medication | 5 | 1 | 7 | 0 |
| Total | 25 | 4 | 16 | 2 |

It was positive to find the Pharmacy realized its omission of reporting these medication variances and took corrective action. In comparing the July report to August report, the number of variances had decreased. A review of the of the medication variance data found no medication variances reported for the physicians or dentist. In order to accurately report medications variances, all disciplines responsible for medication administration practices must report medication variances. The Facility should ensure that all disciplines report their medication variances, including the physicians and dentist.

As had been reported in past compliance reviews, the combined meetings with the Mental Health Hospital, ICF-MR, Inpatient Pharmacy with the Medication Management Work group does not allow adequate time to focus on tracking, analyzing, and trending the ICF-MR Facility's medication variances and does not comply with the DADS Medication Variance Policy, 053. The Nursing Department should adapt the final DADS Medication Variance, Policy Number: 053, to ensure that they are complying with current information for managing and reporting medication variances. After reviewing the low incidents of medication errors/variances reported in the self-assessment and Medication Variance Database, the Monitoring Teams discussed the concern that they were being underreported with the CNE, QE Nurse, and Nurse Educator. They agreed that they were probably underreporting. However, there was no indication as to what they might do to evaluate underreporting of medication errors/variances. The Nursing Department should evaluate the possibility of underreporting medication errors/variances and take corrective action to ensure that all medication errors/variances are reported according to DADS Medication Variance Policy, 053.

The Facility continued to report, analyze and trend through the use of a comprehensive Medication Variance Database: Overall monthly and quarterly variance data by location (Mental Health Hospital, ICF-MR Facility, Outpatient Pharmacy and Inpatient Pharmacy) comparing Fiscal Year 2011 to 2012 to date. The ICF-MR medication variance data was separated from the other components of this facility, which reported: total monthly medication variances, number by home/unit, per shift, per day of the week, per Severity Index Classification, node of variance, type of variance, cause of variance, contributing

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | factors, medications involved in variance, staff identified as initiating variance, discipline identified involved, and quarterly summary of variances. A copy of the CATW2 was attached to the report, but there were no plans of corrective action developed and implemented for the quarterly summaries. The database provided many factors associated with the medication variances. The Facility should better utilize data derived from the medication variances to take corrective actions.<br><br>A review of the Medication Error Investigations for the seven most recent errors reported found:<br>• Seven of seven (100%) errors were reported to the physician.<br>• Seven of seven (100%) errors had corrective action taken.<br>• One of seven (14%) errors was reported within 24 hours.<br>• Two of seven (29%) errors were reported after three or more days. One error was reported on 5/31/12. The error went back to January 2012 at the time of the 120 day update. The individual was receiving Keppra 1500 mg; the order was entered correctly into CWS but the Pharmacy entered the order as Keppra 500 mg. The pharmacy profiled the wrong dose within the system and was followed by nursing without question.<br>• Four of seven (57%) errors did not include the date they were discovered.<br>• Six of seven (86%) errors included the Severity Index Classifications. One error was classified as B, a variance occurred but the medication did not reach the individual. Two errors were classified as C, variances occurred that reached the individual but did not cause harm. Three errors were classified as D; variances that occurred that reached the individual and required monitoring to confirm that it resulted in no harm and/or required intervention to preclude harm.<br>The Nursing Department should ensure that medication errors/variances are promptly discovered, reported, and corrective action taken with the nurses committing the medication error/variances to prevent their reoccurrence.<br><br>The Nursing Department conducted monthly Medication Room inspection in both units. The compliance with of the Medication Rooms inspections for March, April, and May 2012 (June and July 2012 inspection reports were not made available for review.) showed:<br><u>El Paisano</u><br>• March – 98%<br>• April – 96%<br>• May – 93%<br><u>La Paloma</u><br>• March – 100%<br>• April – 82% | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • May – 96%<br><br>The Medication Room inspections were completed by the Infection Control Nurse. Areas found deficient had plans of corrections, which included opening the emergency box in La Paloma for "non-emergency needs." The staff were instructed to adhere to the policy; with emphasis to contact the Pharmacy Department when the emergency boxes were opened. The Monitoring Team's inspection found that the Medication Rooms, Treatment Rooms, and Nursing Offices were much cleaner and freer from unnecessary clutter since the last compliance review. The Nurse Educator stated he had housekeeping clean these rooms weekly. The August 2012 temperatures for all medications/lab materials, and individuals' food stuff were checked daily. The refrigerators were clean with food stuff, medications, and lab materials stored properly. There were no other improperly stored medications or food stuff noted. At the last review, the adaptive equipment was not properly sanitized, rather they were washed by the nursing staff and appear to contain residue from improper washing. Since then, the adaptive equipment was sent to the kitchen for proper sanitation. The white plastic spoons had been replaced with hard plastic maroon spoons. A new refrigerator was ordered for one of the antiquated medication/lab refrigerators. New medication carts were ordered for both units to replace the worn-out and poor working carts. This was a significant improvement from last compliance reviews.<br><br>A review of both units; Medication Administration Record Notebooks found current signature sheets for nursing staff administering medications. Control Drug Sheets were replaced daily, Monday through Friday, by the Pharmacy. The Units' Control Drug Sheets at the time of the noon review were co-signed by pharmacy staff and the nurses receiving the daily supply of control drugs. All individuals had a current Physical/Nutritional Management Plan (PNMP) with instructions for medication administration and pictures of adaptive equipment needed for specific individuals. A review of the Self-Administration of Medication (SAM) Programs showed that data was recorded by the nursing staff on the 6-2 shift for Individuals' who had a SAM program.<br><br>A review of the TRUE TRACK Blood Glucose Monitoring Daily Quality Control Records, April through July 2012, for Individuals #140, #139, #33, #150, #108, #5, and #82, found: The individual Glucometers were consistently checked daily on the 10-6 shifts. The TRUE TRACK testing materials used at the time of the compliance visit were in date.<br><br>Medication Administration Observations were completed alternately by the Nursing Operation Officer (NOO), Nurse Educator, and QE Nurse. It was of serious concern what negative impact the high turnover rate of the nursing administrative and management staff might be having on the Nursing Departments' ability to adequately conduct | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Medication Administration Observations and routine monitoring of medication administration practices. This was further compounded by the concern over the unfilled position of the NOO and Unit Nurse Manager with the Nurse Educator attempting to fulfill the responsibilities for the NOO and Unit Nurse Manager in addition to the Nurse Educator responsibilities. There was no process in place for inter-rater reliability. The Self-assessment reported that 100% of the nurses administering medication had had Medication Administration Observations completed for the second and third quarter for 2012. This was validated through review of the Medication Administration Observation completed schedule. The fourth quarter's 2012 Medication Administration Observations were in process and will be reviewed at the next compliance review. The overall percentage of compliance reported for the Monthly Medication Administration Observations for 2012 showed:<br>• January – 95%<br>• February – 95%<br>• March – 90%<br>• April – 91%<br>• May - 93%<br>• June – 96%<br>There were no reports for July, as mentioned above; with the absence of the NOO and Unit Nurse Manager it was questionable if the Medication Administration Observations were completed. There was a monthly CATW2 developed for deficiencies identified on the Medication Administration Observations provided for review. However, there was no follow-up information provided to ensure that the CATW2s were implemented, followed through to resolution, or evaluation of the effectiveness of the CATW2s implemented.<br><br>Since the last compliance review the Speech and Language Therapist had provided the nursing staff with training on 6/28/12. Review of signed Training Rosters validated the nursing staff had received training in the NEO-Speech Training for: Dysphagia; Aspiration/Choking; Dysphagia Texture; Thickening Liquids Demonstration; Communication; Hearing Aids; AAC Devises; and AAC Device Demonstration. However, the percentage of nursing staff that were trained was not analyzed and summarized. It is essential that the Nursing Department ensure that 100% nursing staff received this basic dysphagia training. In addition, the Nursing Department should collaborate with the Habilitation Therapist to include the recently developed and implemented State Office Medication Administration Training for Dysphagia and Physical and Nutritional Management to ensure safe medication administration practices. There was no documentation present to review that indicated the nurses were trained on each individual's PNMP. The Nursing Department should collaborate with the Habilitation Department to ensure that nurses administering medications receive individualized | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | competency-based training as dictated by the PNMP and its level of detail.<br><br>The Monitoring Team, accompanied by the CNE, Nurse Educators, and Quality Enhancement Nurse, conducted Medication Administration Observation in La Paloma and El Paisano at the noon medication pass on 8/29/12. It was positive to find that the direct support staff assisted the nurses by bringing one individual at a time to receive medication.<br>• The nurse observed in La Paloma followed accepted standards of medication administration, including reviewing each individual's PNMP before administering medication, and except performing the third medication check. She was prompted "on the spot" to perform the third medication check before disposing of the bubble package.<br>• The nurse observed in El Paisano failed to follow all accepted standards of medication administration, as listed below:<br>o Failed to consistently tell individuals the name and purpose of the medications they were receiving.<br>o Failed to consistently refer to the individual's PNMP.<br>o Failed to perform the third medication check. Once the medications were removed out of the bubble package, the package was immediately disposed of in the waste.<br>o Individual #51's PNMP required a built-up handle spoon when administering medication mixed only with applesauce or with honey-thickened liquids in a cup. He did not have a built-up handle spoon available for use. His medications were given in a cup with honey thickened liquids. The nurse was prompted to secure a built-up hand spoon for medication administration.<br>o Individual #35 was half way through a 14 day regimen of Prevpac for H-Pylori. Her medications administration instruction on the PNMP stated to crush medications and give with applesauce. The amoxicillin was in a capsule form that could not be crushed. The physician who ordered the Prevpac, as well as the Pharmacy and nursing should have known that Individual #35's medication had to be crushed and ordered the medication in a liquid form. The Monitoring Team caught the wrong preparation and notified the CNE who stopped administration of the medication and had the nurse call the physician "on the spot" to order a liquid form of amoxicillin. The order was changed to a liquid form and the Pharmacy immediately filled the order without delaying the dose. It was doubtful that the wrong preparation would have been caught had the Monitoring Team not been observing the medication pass. The prescribing, dispensing, and administering the wrong preparation of the Prevpac amounted to a medication variance and should have been reported as such. After the amoxicillin capsule was removed from the package and discovered to be the | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | wrong preparation, the nurse threw it in the waste, as opposed to properly disposing of it by sending it back to the Pharmacy. When the Monitoring Team asked the nurse if that was the proper way to dispose of the medications, she stated that it was okay to throw it in the waste. She stated only medications that were dropped or accidently crushed were sent back to the Pharmacy for disposal. The improper disposal of medication should also be considered a medication variance and reported as such.<br><br>A review of Individual #35's Medication Administration Record was hand written by the nurse for the change of the Prevpac medications to liquid form; the nurse failed to document allergies/adverse drug reactions or diagnoses. The Nursing Department should re-train the nursing staff on proper disposal of medications. The Nursing Department should ensure when the nursing staff add medications onto the Medication Administration Record, not printed by the pharmacy, that allergies/adverse drug reactions and diagnoses are entered.<br>o The nurse administering Individual #62's medication prepared and started to administer his medication without checking the Medication Administration Record. She said she knew what medication he was to receive. She was prompted "on the spot" to check the medication with the Medication Administration Record before administering. Individual #62's PNMP medication administration instructions called for liquids to be administered using a Wonder-Flo cup. The cup was used but as he started drinking from the cup he began hyperextending his head. Even with prompting the nurse did not stop his drinking with his head hyperextended and redirect him not to hyperextend.<br><br>The nurse administering medications in El Paisano should receive re-training on accepted standards of medication administration practices and on the individual's PNMP as well as foundational training on physical and nutritional management. In addition, this nurse should have increased monitoring until she demonstrates appropriate medication administration practices.<br><br>As was found in past compliance reviews, the nursing staff continued to split tablets to make the required dose 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 Therapy Sub-Committee gave approval for the nurses to continue to split tablets. The practice of requiring nurses to split tablets to make the correct dosage is not in keeping with generally accepted medication administration practices. Split tablets are often unequal and a substantial amount of the tablet can be lost during splitting that can lead to inaccurate dosing and ineffective medical management. There can be a narrow margin between therapeutic and toxic | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | doses for medications that are split. Therefore, every effort should be made to procure the correct dosage of medications. The practice of requiring the nursing staff to split pills to make the correct dosage of medication should be addressed by the State Office Pharmacy Coordinator and Nursing Coordinator.<br><br>As found in past reviews, 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. The MediMar computer system frequently goes down. When this happened, paper Medication Administration Records were used, thus creating duplicate records that have the potential to cause medication errors/variances. As reported in the past, the CNE stated the Facility was required to use the MediMar system because it was linked to and used by the Mental Health Hospital, Outpatient Clinic, and In and Out Patient Pharmacy.<br><br>Although this Provision was not found in substantial compliance, the Facility should maintain the positive practices identified in the report and make improvements in the following practices:<br>• The Facility should adopt and localize the final DADS Medication Variance, Policy Number: 053 to ensure compliance with the policy.<br>• The Facility should ensure that all disciplines report their medication variances, including the physicians and dentist.<br>• The Nursing Department should evaluate the possibility of underreporting medication errors/variances and take corrective action to ensure that all medication/variances are reported according to DADS Medication Variance Policy, 053.<br>• The Facility should better utilize data derived from the medication variances to take corrective actions.<br>• The Nursing Department should ensure that medication errors/variances are promptly discovered, reported, and corrective action taken with the nurses committing the medication Variance to prevent reoccurrence.<br>• The Nursing Department should collaborate with the Habilitation Therapist to include the recently developed and implemented State Office Medication Administration Training for Dysphagia and Physical and Nutritional Management to ensure safe medication administration practices.<br>• The Nursing Department should collaborate with the Habilitation Department to ensure that nurses administering medications receive individualized competency-based training as dictated by the PNMP and its level of detail.<br>• The Nursing Department should re-train the nursing staff on proper disposal of medications. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • The Nursing Department should ensure when the nursing staff add medications onto the Medication Administration Record, not printed by the pharmacy, that allergies/adverse drug reactions and diagnoses are entered.<br>• The practice of requiring the nursing staff to split pills to make the correct dosage of medication should be addressed by the State Office Pharmacy Coordinator and Nursing Coordinator. | |

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

1. The Nursing Department should make every effort to secure additional nursing positions and continue to recruit and retain full time nursing staff. (Provision M.1)
2. The Nursing Department should ensure that all Nursing Care Monitoring Tools are completed according to schedule, sent to the Quality Enhancement Department to enter into the Quality Enhancement Database, analyzed, and trended for compliance. For the tools falling below 90%, a systemic CATW2 should be developed, implemented, and followed through to resolution. (Provision M.1)
3. The Infection Control Program should: (Provision M.1)
    - Report, track, and monitor individuals identified as carriers for various contagious organisms/diseases.
    - Develop and implement a system for tracking nurses' reporting of infections, to ensure "real time" investigations are conducted on all infections.
    - Review all infection related ACPs for appropriateness and individualization to ensure they are sufficient to meet the individuals' specific needs. Review the ACPs to ensure they are consistent with the Antibiotic Therapy Protocol. Provide the nursing staff with technical assistance to improve quality of the ACPs to ensure they include all relevant infection control preventative measures/interventions.
4. The Nurse Educator should ensure that all nurses are trained on the revised Emergency Response Policy and emergency equipment. (Provision M.1)
5. The Nursing Department should ensure: (Provision M.2)
    - The RN Case Managers complete an addendum to the Annual/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 health care plans for changes in status.
    - The RN Case Managers summarize each nursing problem/diagnosis separately for clarity.
    - The RN 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 RN Case Managers.
    - The RN Care Managers attend the mandatory Physical Assessment and Documentation Class.
6. The Nursing Department should ensure: (Provision M.3)
    - Integrated Health Care Plans (IHCPs) address all high and/or medium risk indicators and active problems that require nursing interventions.
    - IHCPs are individualized to meet individuals' specific health care needs in relation to their identified risks and/or active medical problems.
    - IHCPs 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 IHCPs include proactive/preventative measures to reduce and/or eliminate risk indicators/problems.
- ACPs and IHCPs contain integrated interventions in collaboration with other relevant disciplines, as required in Sections G and F of the Settlement Agreement.
- ACPs and IHCPs 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.
- All Nursing Protocols are incorporated into the ACPs and followed through to resolution.

7. The Nursing Department should: (Provision M.4)
    - Ensure that all nurses consistently receive 100% of required nursing training and training records are accurately reported in the Monthly Nursing Training Tracking Database.
    - Ensure that the nursing staff follow all Nursing Protocols.
    - Collaborate with the Habilitation Therapist to include the recently developed and implemented State Office Medication Administration Training for Dysphagia and Physical and Nutritional Management to ensure safe medication administration practices.
8. The Nursing Department should ensure: (Provision M.5)
    - The newly hired RN Case Managers are adequately trained and supported in their roles and responsibilities related to the Integrated Risk Rating and Health Care Plan process.
    - The shift nurses are adequately competency-based trained on checking and initialing the Aspiration Trigger Data and following up with nursing assessment on individuals reported to have triggers. The Nursing Department should ensure that the RN Case Managers or other RNs in their absence, review the Aspiration Trigger Data Sheet daily, at least Monday through Friday.
9. The Facility Program Director should ensure that the direct support professional staff are adequately competency-based trained on completing the Aspiration Trigger Data Sheets on individuals who require aspiration monitoring and that they are monitored by their respective supervisor to ensure they adhere to the requirement, as well as notification of the nursing staff when individuals develop triggers. (Provision M.5)
10. The Facility should adopt the final DADS Medication Variance, Policy Number: 053 to ensure compliance with the policy. (Provision M.6)
11. The Facility should ensure that all disciplines report their medication variances, including the physicians and dentist. (Provision M.6)
12. The Nursing Department should evaluate the possibility of underreporting medication errors/variances and take corrective action to ensure that all medication/variances are reported according to DADS Medication Variance Policy, 053. (Provision M.6)
13. The Facility should better utilize data derived from the medication variances to take corrective actions. (Provision M.6)
14. The Facility should ensure that all disciplines report their medication variances, including the physicians and dentist. (Provision M.6)
15. The Nursing Department should:
    - Ensure that medication errors/variances are promptly discovered, reported, and corrective action taken with the nurses committing the medication Variance to prevent reoccurrence. (Provision M.6)
    - Collaborate with the Habilitation Therapist to include the recently developed and implemented State Office Medication Administration Training for Dysphagia and Physical and Nutritional Management to ensure safe medication administration practices.
    - Collaborate with the Habilitation Department to ensure that nurses administering medications receive individualized competency-based training as dictated by the PNMP and its level of detail.
    - Re-train the nursing staff on proper disposal of medications.
    - Ensure when the nursing staff add medications onto the Medication Administration Record, not printed by the pharmacy, that allergies/adverse drug reactions and diagnoses are entered.
16. The State Office Pharmacy Coordinator and Nursing Coordinator should address the practice of requiring the nursing staff to split pills to make the correct dosage of medication. (Provision M.6)

The following are offered as additional suggestions to the Facility:

1. The Facility should expect physicians to participate in the Mock Medical Emergency Drills, unless there are justifiable reasons that they cannot not participate. (Provision M.1)
2. Conduct Mock Medical Emergency Drills using a variety of scenarios that have the potential to be life threatening, which are identified in the Emergency Response Policy. (Provision M.1)
3. Ensure consistency in reporting seizure activity data into the Crystal Reports, Medical Observation Inquiry Reports, and the Integrated Progress Notes. Further, the Facility should evaluate the effectiveness of the seizure report system in making clinical decisions. (Provision M.1)
4. The Facility should develop and implement a skin integrity system for monitoring, reporting, tracking, analyzing, and trending skin breakdowns/decubitus ulcers/skin integrity issues. (Provision M.1)
5. 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)
6. The Facility and State should give serious reconsideration of eliminating the two RN Case Manager positions if individuals are to receive nursing care sufficient to meet their health care needs and to protect them from harm. (Provision M.5)
7. The Facility should ensure that the other disciplines consistently and timely provide the RN Case Managers 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)
8. The State Office Nursing Coordinator and/or Nurse Practitioner Consultant should continue to provide the Nursing Department with technical assistance in defining and clarifying the RN Case Managers' role and responsibilities for the revised Integrated Risk Rating Form and Integrated Health Care Plan Processes. (Provision M.5)

| 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:**<br>**Documents Reviewed:**<br>1. RGSC Self-Assessment 8/13/12<br>2. RGSC Action Plan 8/9/12<br>3. RGSC Section N Presentation Book<br>4. RGSC Standard Operating Procedure PH100-012-01-01, dated December 1, 1999<br>5. RGSC Standard Operating Procedure PH100-059, Metabolic Syndrome Monitoring Policy, dated 5/12<br>6. Medication orders, and associated communication forms, and single patient drug intervention reports for the first ten new medication orders written in June, July, and August of 2012<br>7. Completed QDRR reports, and worksheets for individuals #134, #26, #1, #31, #63, and #48.<br>8. QDRR schedule for 2011-2012.<br>9. All Pharmacy and Therapeutics Committee (P&TC) minutes developed during the review period.<br>10. Copy of Face-to-Face assessments for all STAT chemical restraints that occurred during the reporting period, and associated data, and analysis of the use of STAT chemical restraints<br>11. Ten QDRRs that were randomly selected by the Facility, from a list of individuals that were screened positive for metabolic syndrome<br>12. Ten most recent QDRRs on which the prescribing physician did not agree with the pharmacist's recommendations, and documented evidence of the physician's clinical rationale for not following the recommendations, and action plan<br>13. Standard Operating Procedure PH100-019-01-02, Reporting Adverse Drug Reactions to the Food and Drug Administration, revised 9/11<br>14. Completed Adverse Drug Reaction (ADR) forms, and associated reports for ADRs that were reported on Individuals #33, and #77<br>15. Medical staff summary of Drug Utilization Evaluation (DUE) result, for June through August 2012<br>16. Medication Variance Reports for in-patient pharmacy, and living areas, for last six months<br>**People Interviewed:**<br>1. Anne Ikponmwomba, R.Ph<br>2. David Moron, MD, Clinical Director<br>3. Dr. Dill, MD, RGSC Medical Director<br>**Meeting Attended/Observations:**<br>1. None |
| | **Facility Self-Assessment:**<br>The Monitoring Team concurs with the Facility's self-assessment of noncompliance for Provisions N2 through N3, and N6 through N8.<br><br>Because of significant improvement with documenting the review of new medication orders, and providing physicians with meaningful recommendations when identifying a potential issue with a new medication order, the Monitoring Team disagreed with the Facility's self assessment of noncompliance with Provision |

| | |
|---|---|
| | N1, and rated substantial compliance.<br><br>The Facility self-assessed noncompliance for Provision N5; however, upon review of MOSES and DISCUS assessments, through review for Provision J12, of this report, the Monitoring Team noted complete, and comprehensive side effect monitoring of psychotropics, and determined the Facility to be in substantial compliance with Provision N5.<br><br>The Facility reported that it was in substantial compliance with Provision N4, stating that the physician's disagreement with the pharmacist's recommendation is documented in the WORx program, and /or documents on the hard copy of the order. The Monitoring Team disagrees with the Facility's self-assessment because the physicians do not regularly document their clinical rationale for disagreeing with the pharmacist, and they do not regularly document an alternative action plan, based on sound clinical judgment. |
| | **Summary of Monitor's Assessment:**<br>The Monitoring Team noted significant improvement with organizational efforts within the pharmacy department. For example, documentation of QDRRs was concise, several new policies were developed for pharmacy operations, and steps taken to work towards compliance were effectively conveyed to the Monitoring Team. The Monitoring Team noted marked improvement with follow-up efforts on review of new medication orders, and rated substantial compliance for Provision N1. Also, much improvement was noted with Provision N2, by enhancing its review process for QDRRs. The pharmacy; however, has many noted deficiencies that must be addressed before substantial compliance can be achieved. The following are specific comments for Provisions N1 through N8<br><br>Provision N1: The Monitoring Team would like to acknowledge the high quality of medication regimen reviews conducted by the dispensing pharmacist, when completing new medication orders. For example, the dispensing pharmacists identified that Calcium and Dilantin were prescribed at the same time, and recommend that the medication be spaced out by two hours; the pharmacist identified that the dose of vitamin D was excessive and recommend adjusting the frequency of the medication; another example was the pharmacist questioning a dosing frequency that was outside of the manufacturer's recommendations, and when the physician indicated no change, the pharmacist conducted a literature review, that supported more frequent dosing of the medication for the specific indication. Because new medication orders were appropriately reviewed, and documented evidence supported a thorough review by the dispensing pharmacist, the Monitoring Team determined that the Facility is in substantial compliance with Provision N1. The Monitoring Team had discussed with the director of pharmacy that the labels used to verify their review of new medication orders would be updated to include a laboratory review. It was apparent to the Monitoring Team that the Facility's standard operating procedure PH100-012-01-01, dated December 1, 1999 was updated; however, the current version did not include a revision date, and the Monitoring Team encourages the Facility to ensure that all policies and procedures indicate the date of any review and/or changes made to the document.<br><br>Provision N2: The Monitoring Team noted significant improvement with the QDRR process. For example, |

| | |
|---|---|
| | a new QDRR worksheet was developed that more clearly delineates the clinical assessment for the QDRR, and more assertive documentation of laboratory results was noted. Although the Monitoring Team determined that the Facility remains not in compliance with Provision N2, the Monitoring Team is hopeful that the Facility will be able to enhance its practice, and ensure more comprehensive reviews in the future. Compliance will requires that the use of benzodiazepines, anticholinergics, polypharmacy, and STAT medications are included in the review clearly and clinical appropriateness clearly delineated; all necessary diagnostics, including ophthalmologic examinations for individuals on Seroquel, periodic EEGs, seizure log review for individuals on antiepileptics, and robust monitoring of blood pressure for individual diagnosed and treated for hypertension; include waist circumference when assessing metabolic syndrome, and ensure that if an individual is diagnosed with a risk factor condition, such as hyperlipidemia, diabetes, and hypertension, that it is documented and included as a risk factor, despite the condition being controlled by treatment; ensure that all side effects documented on the MOSES, are not potentially contributed by prescribed medications, and that if the Individual has an abnormal DISCUS score, that it is being addressed appropriately by the physician – in general, any condition that is potentially caused by a prescribed medication, must be addressed by the pharmacist; Whenever a QDRR includes a review for psychotropic medications, the psychiatrist must sign the QDRR report, in addition to the primary care provider; the pharmacist is also responsible to assist the physician in determining the efficacy of medications.<br><br>Provision N3: The Pharmacy department has made moderate improvement in working towards compliance with Provision N3; however, at the time of this review, the Monitoring Team determined that the Facility remains not in compliance with the Provision. Compliance will require enhancement of its metabolic syndrome reviews, which must include abdominal circumference, documentation of a comprehensive review of metabolic syndrome on the QDRR report, and ensure that there are robust clinical recommendations on how to address metabolic syndrome, and/or risk factors for metabolic syndrome. Importantly, the IDT must be made well aware of all individuals who meet or exceed three screening criteria for metabolic syndrome, and those known to be at considerable risk, when on a medication that is known to manifest metabolic syndrome. The P&TC must enhance its review process for the use of STAT medications, when used for chemical restraints, and the face-to-face assessment must include a comprehensive review and recommendations by both the psychiatrist and pharmacist, for example the justification for the use of the STAT medication, whether the maintenance medication and/or behavioral support program should be adjusted, noted side effects and adverse effects, risk and benefits, and recommendations, should all be well documented by both the psychiatrist and pharmacist on the face-to-face assessment. The Facility must develop and implement a process to review the use of polypharmacy, benzodiazepines, and anticholinergics for each individual prescribed such medications, and as part of a systems review. QDRRs should clearly document noted clinical rationale, alternative treatments, risks and benefits, and provide meaningful recommendations.<br><br>Provision N4: Because the primary care physician did not document the clinical rationale for not following the pharmacists recommendations, and indicating an action plan, the Monitoring Team determined that the Facility was not in compliance with Provision N4. It is essential that all instances when the physician does not follow the recommendations by the pharmacist a clinical rationale for not following the recommendations is well documented, along with an alternate action plan. Sample #77 was of significant |

| | |
|---|---|
| | concern because the pharmacist was concerned over a QTc of greater then 400, in a Individual who was prescribed an atypical antipsychotic, and the physician disagreed with the pharmacists recommendation, but did not document the clinical rational, or follow-up plan. In a second example, Individual #33, the pharmacist recommended that the psychiatrist reassess the combination of Mellaril and Quetiapine, and although the psychiatrist documented agreement with the pharmacist, the psychiatrist did not document a meaningful action plan to enhance monitoring of the individual or perhaps altering the medication regimen.<br><br>Provision N5: The Facility's utilization of side effect scales is reviewed as a component of Provision J12, of this report. Following its review of the MOSES and DISCUS side effect scales, the Monitoring Team determined that the Facility is in substantial compliance for Provision J12, and Provision N5.<br><br>Provision N6: Because the Facility did not have a comprehensive, functional, and well-established process to address ADRs, the Monitoring Team determined that the Facility was not in compliance with Provision N6, of the Settlement Agreement. The Facility must develop and implement a process that ensures robust monitoring, clinical assessment, reporting, and follow-up on all ADRs. All relevant staff including nurses, physicians, direct care staff, and pharmacists must be well trained on the Facility's ADR process.<br><br>Provision N7: Review of compliance with Provision N7 indicated that the Facility did not have a functional DUE process in effect during the reporting period. Although the Facility updated its policy for DUE, there was no evidence to support implementation of the policy. The Facility's DUE process must be enhanced to ensure that DUEs are provided beyond the scope of it's current practice. For example, a DUE may have been developed for an ADR related to a prolonged QTc value, secondary to a prescribed medication. DUEs must be readily provided when other unusual and unexpected outcomes are noted at the Facility. Importantly, DUEs must be provided for all relevant FDA and/or Manufacturer advisories. Longitudinal data on DUEs should be collected for trends analysis. Educational venues should be developed for relevant staff, such as physicians, nurses, pharmacists and direct care providers on issues related to the DUE. 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.<br><br>Provision N8: The Monitoring Team was exceptionally pleased with improvements made by the Facility with regards to Provision N8, including the development and implementation of a medication workgroup, and its enhancement of the reporting and review process for medication variances, by developing a very useful graphing tool to capture medication variance data elements. The Facility is aware that it must continue to enhance its reporting, and monitoring of medication variances, and ensure that all relevant staff, including physicians, nurses, and pharmacists are provided regular in-services on the Facility's medication variance process. Importantly, physician service must participate in reporting on prescriber's variances. Also, a process for remediation of staff, and administrative action for repeated medication variances by staff, must be developed and implemented. The Monitoring Team would like to compliment all staff members who were involved with working towards compliance for Provision N8. |

| | |
|---|---|

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| N1 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature. | To assess compliance with Provision N1, the Monitoring Team reviewed the first ten medication orders written in June, July, and August, of 2012. A total of 30 new patient order forms were reviewed, In addition, the Facility's standard operating procedure PH100-012-01-01, dated December 1, 1999 was reviewed.<br><br>Of the 30 new medication orders reviewed, 27 out of 30 (90%) demonstrated a thorough review by the dispensing pharmacist, and included a signed and dated label indicating review of allergies, dose, indication, and drug interactions. In addition, the pharmacist noted that two out of 30 new medication orders required review of laboratory studies, and appropriately reviewed necessary laboratory studies in two out of two samples (100%). The Monitoring Team reviewed all thirty new medication orders and noted that 30 out of 30 (100%) included appropriate diagnoses, listed allergies or otherwise indicated no allergies, and that the orders were signed, dated and timed. Of the thirty new medication orders, five required the pharmacist to notify the physician of a potential conflict with the medication order. In five out of five samples (100%), the pharmacist appropriately identified a potential medication order conflict, notified the prescribing physician, and appropriately followed-up to ensure that the issue was addressed.<br><br>Summary<br>The Monitoring Team would like to acknowledge the high quality of medication regimen reviews conducted by the dispensing pharmacist, when completing new medication orders. For example, the dispensing pharmacists identified that Calcium and Dilantin were prescribed at the same time, and recommend that the medication be spaced out by two hours; the pharmacist identified that the dose of vitamin D was excessive and recommend adjusting the frequency of the medication; another example was the pharmacist questioning a dosing frequency that was outside of the manufacturers recommendations, and when the physician indicated no change, the pharmacist conducted a literature review, that supported more frequent dosing of the medication for the specific indication. Because new medication orders were appropriately reviewed, and documented evidence supported a thorough review by the dispensing pharmacist, the Monitoring Team determined that the Facility is in substantial compliance with Provision N1. The Monitoring had discussed with the director of pharmacy that the labels used to verify their review of new medication orders would be updated to include a laboratory review. It was apparent to the Monitoring Team that the Facility's standard operating procedure PH100-012-01-01, dated December 1, 1999 was updated; however, the current version did not include a revision date, and the Monitoring Team encourages the Facility to ensure that all policy's and procedures indicate the date of any review and/or changes made to the document. | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | | |
| N2 | Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values. | To assess compliance with Provision N2, the Monitoring Team reviewed the Facility's quarterly drug regimen review (QDRR) schedule, and the Facility's newly developed QDRR worksheet. In addition, the Facility was requested to provide the QDRRs of five individuals for May, and five individuals for June, along with associated psychiatric assessments, medication list, EEG's, EKGs, MOSES and DISCUS assessment; the Monitoring Team was provided the QDRR for Individuals #134, #26, #1, #31, #63, and #48. MOSES and DISCUS assessments for these individuals were not provided in response to the document request.<br><br>Review of the QDRR schedule did not enable the Monitoring Team to determine the actual date that the QDRR was completed, as it only listed the date the QDRR was scheduled t be completed. Tracking documentation must also include when the QDRR was actually completed.<br><br>Review of the newly developed QDRR worksheet demonstrated significant improvement over previously used worksheets. The worksheet did not include a review of benzodiazepines, anticholinergics, or the use of STAT medications. The worksheet required that blood pressure be assessed only once per month for individuals treated for hypertension, and it did not specifically require abdominal waist circumference to be evaluated for individuals on antipsychotics. Importantly, the worksheet appears not to consider a risk factor, such as hyperlipidemia, a positive risk factor for metabolic syndrome, if the condition was being treated. During discussion with the pharmacy director, the Monitoring Team was informed that STAT medication use, use of benzodiazepines, and anticholinergics were not being assertively assessed during the QDRR process.<br><br>An example of one QDRR which was completed using the current QDRR worksheet is as follows: Individual #134 was prescribed a benzodiazepine, and the pharmacists did not comment on the use of benzodiazepine; Seroquel was prescribed and there was no comment about assessment for cataracts, and potential need for serial EKGs because of a history of a QTc greater then 400 M; psychotropic medications were prescribed and the psychiatrist did not sign the QDRR report; despite noted polypharmacy, there was no comment on its appropriateness, just a statement that the psychiatrist is monitoring the Individual; there was no indication of the results of the MOSES assessments; despite being prescribed an atypical antipsychotic, there was no comment about metabolic syndrome.<br><br>Summary<br>The Monitoring Team noted significant improvement with the QDRR process. For example, a new QDRR worksheet was developed that more clearly delineates the clinical | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | assessment for the QDRR, and more assertive documentation of laboratory results were noted, and although the Monitoring Team determined that the Facility remains not in compliance with Provision N2, the Monitoring Team is hopeful that the Facility will be able to enhance its practice, and ensure more comprehensive reviews in the future. Compliance will requires that the use of benzodiazepines, anticholinergics, polypharmacy, and STAT medications are included in the review clearly and clinical appropriateness clearly delineates; all necessary diagnostics, including ophthalmologic examinations for individuals on Seroquel, periodic EEGs, seizure log review for individuals on antiepileptics, and robust monitoring of blood pressure for individual diagnosed and treated for hypertension; include waist circumference when assessing metabolic syndrome, and ensure that if an individual is diagnosed with a risk factor condition, such as hyperlipidemia, diabetes, and hypertension, that it is documented and included as a risk factor, despite the condition being controlled by treatment; ensure and document that all side effects noted on the MOSES, are not potentially contributed to by prescribed medications, and that if the Individual has an abnormal DISCUS score, that it is being addressed appropriately by the physician – in general, any condition that is potentially caused by a prescribed medication must be addressed by the pharmacist; Whenever a QDRR includes a review for psychotropic medications, the psychiatrist must sign the QDRR report, in addition to the primary care provider; the pharmacist is also responsible to assist the physician in determining the efficacy of medications. | |
| 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 with Provision N3, the Monitoring Team assessed the Facility's ability to monitor and address issues related to the use of STAT chemical restraint, and utilization of benzodiazepines, anticholinergics and polypharmacy.<br><br><u>STAT Medications</u><br>To assess the use of STAT medications, the Monitoring Team requested a copy of the face-to-face documentation for all STAT chemical restraints during the past six months, STAT medication usage reports, data, and analysis for the past six months, and pharmacy and therapeutic committee (P&TC) meeting minutes reflecting review of STAT medications during the past six months.<br><br>Tracking data for the use of STAT chemical restraint indicated that STAT chemical restraints were administered on five occasions in May through June 2012, with two applications in March and three in June. Completed face-to-face assessments did not include a component for the physician and pharmacist to complete.<br><br>Two sets of P&TC minutes were provided for review. Both sets of minutes were dated June 13, 2012. Only one set was signed by the committee chairperson, and the signature was dated 8/29/12. Both sets of minutes did not reflect meaningful review of STAT chemical restraint use at the Facility. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Based on the information provided, the Monitoring Team determined that the Facility did not document that prn medications were used in a justifiable manner, and not as a substitute for long-term treatment.<br><br><u>Metabolic Syndrome</u><br>To assess screening for metabolic syndrome, the Monitoring Team reviewed the Facility's new standard operating procedure PH100-059, Metabolic Syndrome Monitoring Policy, dated 5/12 (no day provided), ten QDRRs that were randomly selected by the Facility, from a list of individuals that were screened positive for metabolic syndrome, and P&TC draft minutes for the 8/28/12 P&TC meeting.<br><br>The Facility's new metabolic syndrome monitoring policy was noted to have a significant error. The policy stated the criteria for the identification of metabolic syndrome shall be adopted from the American Diabetes Association, and include the assessment of waist circumference; however, the procedure, as outlined in the policy, did not include waist circumference as a risk factor for metabolic syndrome, but instead indicated that the Facility would rely on Body Mass Index (BMI)). BMI should not be used as a determining factor for metabolic syndrome, and waist circumference must be used as a parameter.<br><br>The 8/28/12 P&TC minutes reflected a systems review for metabolic syndrome. The minutes stated that 71 individuals had been assessed, eight of whom were diagnosed with metabolic syndrome, and an additional 9 that met criteria and will be monitored.<br><br>The Monitoring Team was provided with a total of ten QDRRs to review. Of the ten samples, only six (60%) indicated that an abdominal waist circumference was assessed; and zero out of ten provided clinically relevant comments and recommendations on possible pharmacological, and nonpharmacological strategies on how to enhance management and monitoring of metabolic syndrome.<br><br><u>Benzodiazepine Utilization</u><br>The pharmacy had not developed a process to effectively review its utilization of benzodiazepines, and benzodiazepine review were not currently addressed in the QDRR process. The Facility had established a work group that is assertively developing a process to address benzodiazepines, polypharmacy, and anticholinergic utilization.<br><br><u>Polypharmacy Utilization</u><br>The pharmacy had not developed a process to effectively review its utilization of polypharmacy, and polypharmacy review is not effectively addressed in the QDRR process. The Facility had established a work group that is assertively developing a process to address benzodiazepines, polypharmacy, and anticholinergic utilization. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Anticholinergic Utilization<br>The pharmacy had not developed a process to effectively review its utilization of anticholinergics, and anticholinergics reviews were not effectively addressed in the QDRR process. The Facility had established a work group that is assertively developing a process to address benzodiazepines, polypharmacy, and anticholinergic utilization.<br><br>Summary<br>The Pharmacy department has made moderate improvement in working towards compliance with Provision N3; however, at the time of this review, the Monitoring Team determined that the Facility remains not in compliance with the Provision. Compliance will require enhancement of its metabolic syndrome reviews, which must include abdominal circumference, documentation of a comprehensive review of metabolic syndrome on the QDRR report, and robust clinical recommendations on how to address metabolic syndrome, and/or risk factors for metabolic syndrome. Importantly, the IDT must be made well aware of all individuals who meet or exceed three screening criteria for metabolic syndrome, and those known to be at considerable risk, when on a medication that is known to manifest metabolic syndrome. The P&TC must enhance its review process for the use of STAT medications, when used for chemical restraints, and the face-to-face assessment must include a comprehensive review and recommendations by both the psychiatrist and pharmacist; for example, the justification for the use of the STAT medication, whether the maintenance medication and/or behavioral support program should be adjusted, noted side effects and adverse effects, risk and benefits, and recommendations should all be well documented by both the psychiatrist and pharmacist on the face-to-face assessment. The Facility must develop and implement a process to review the use of polypharmacy, benzodiazepines, and anticholinergics for each individual prescribed such medications, and as part of a systems review. QDRRs should clearly document noted clinical rational, alternative treatments, risks and benefits, and provide meaningful recommendations. | |
| 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 compliance with Provision N4, the Monitoring Team requested the most recent ten QDRRs that the prescribing physician did not agree with the pharmacist's recommendations, and documented evidence of the physicians clinical rationale for not following the recommendations, and action plan.<br><br>Of the ten samples, zero out of ten (0%) demonstrated documented evidence of the physician's clinical rationale for not following the pharmacist's recommendations, and an action plan. In the samples that required review by the psychiatrist, two out of three (67%) documented a meaningful clinical rationale for not following the pharmacist's recommendations. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Examples of issues that concern the Monitoring Team are as follows:<br>1. Individual #77 was of significant concern because the pharmacist was concerned over a QTc of greater then 400, in an individual who was prescribed an atypical antipsychotic, and the physician disagreed with the pharmacist's recommendation but did not document the clinical rationale or follow-up plan.<br>2. Individual #33, the pharmacist recommended that the psychiatrist reassess the combination of Mellaril and quetiapine, and although the psychiatrist documented agreement with the pharmacist, the psychiatrist did not document a meaningful action plan to enhance monitoring of the individual or perhaps altering the medication regimen.<br><br>Summary<br>Because the primary care physician did not document the clinical rationale for not following the pharmacist's recommendations, or did not document an action plan, the Monitoring Team determined that the Facility was not in compliance with Provision N4. It is essential that all instances when the physician does not follow the recommendations by the pharmacist a clinical rationale for not following the recommendations is well documented, along with an alternate action plan. | |
| N5 | Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia. | The reader is referred to Provision J12 of this report for the Monitoring Team's assessment of the Facility's utilization of side effect scales.<br><br>Summary<br>The Facility's utilization of side effect scales is reviewed as a component of Provision J12, of this report. Following its review of the MOSES and DISCUS side effect scales, the Monitoring Team determined that the Facility is in substantial compliance for Provision J12, and Provision N5. | Substantial Compliance |
| 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 determine compliance with Provision N6, the Monitoring Team request copies of all adverse drug reaction (ADR) forms, and tracking and trending analysis for all ADRs that occurred during the monitoring period. In addition, all policies, training materials, and attendance records of trainings provided to staff on the ADR process were requested.<br><br>The Monitoring Team was provided materials for the course "Observing and Reporting Clinical Indicators of Health Status Change" materials and a training rosters of attendees. A policy on reporting adverse drug reactions to the Food and Drug Administration, Standard Operating Procedure PH100-019-01-02, with a revision date of 9/11 was provided for review.<br><br>The Monitoring Team determined that the SOP did not detail a comprehensive process for the identification, reporting, documentation of findings, provision of clinical | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | assessments, development of an action plan for the treatment, continued monitoring and follow-up of the ADR, or training of all relevant staff including nurses, physicians, direct care staff, and pharmacists on the ADR process. The policy also did not specify how the Facility would track and trend ADRs that occur at the Facility.<br><br>For the past six months, the Facility provided the Monitoring Team with two sets of completed ADR forms. Review of the ADR reported bv the nurse on Individual #33 was in fact incorrectly reported, as the ADR was initiated because of an elevated drug level, but no signs or symptoms of an adverse reaction. The physician reviewing the ADR noted the elevated drug level was without associated adverse reaction, and indicated that the issues was not an ADR, and should not have been reported. This example highlights the importance of the need for staff training on the ADR process. The ADR report on Individual #77 was secondary to a prolonged QTc on a recently obtained EKG. The description of the ADR was simply "increased QTc interval", and no other clinical assessment was described, such as the Individual's general condition, or vital signs. The pharmacist response was nothing more then a review of the Individual's current medications, and a brief statement on the additive effects of the medications prescribed, but no recommendations. Importantly, the physician indicated that he agreed that the issue was an ADR, but did not document an assessment of the Individual's condition, or clinical action plan.<br><br>Summary<br>Because the Facility did not have a comprehensive, functional, and well-established process to address ADRs, the Monitoring Team determined that the Facility was not in compliance with Provision N6, of the Settlement Agreement. The Facility must develop and implement a process that ensures robust monitoring, clinical assessment, reporting, and follow-up on all ADRs. All relevant staff including nurses, physicians, direct care staff, and pharmacists must be well trained on the Facility's ADR process. | |
| 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 | To assess compliance with Provision N7, the Monitoring Team requested a copy of the Facility's new policy on Drug Utilization Evaluations (DUE), and a copy of all DUEs, attendance records for DUE in-services, and related materials developed for DUEs during this reporting period.<br><br>Standard Operating Procedure PH100-058: Drug Utilization Evaluation (DUE), dated May 2012 was reviewed and determined to be appropriate for a DUE process.<br><br>There were no formal recommendations offered by the pharmacy for clinicians to consider, and no training materials or attendance records provided to the Monitoring Team for review. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | accepted professional standards of care with regard to this provision in a separate monitoring plan. | The Facility did not maintain a schedule of all pending and completed DUEs.<br><br>The Monitoring Team was provided with a copy of the medical staff summary of DUE result for June through August 2012. The summary indicated that the pharmacy reviewed 19 medications, and determined that common indications for use, and contraindications were addressed in 100%, and that monitoring parameters were completed in 88.9% of the time.<br><br>The Facility did not provide DUEs for recent FDA drug advisories.<br><br>The Monitoring Team was provided with three sets of P&TC minutes. Two sets were dated 6/13/12, one of which was signed and dated on by the P&TC chair on 8/29/12, and the third set was dated 8/21/12, and the content of the two sets were slightly different. Minutes from the P&TC meeting signed and dated 8/29/12 indicated that there was no report available for DUEs, and "place on hold for preparation for DOJ pre and post visit". The unsigned 6/13/12 P&TC minutes indicated some review of DUEs, however there were no specific action steps developed, recommendations, or follow-up, with the exception of "on-going monitoring". The signed 613/12 minutes included the same information for DUEs as the unsigned set. In general, the P&TC did not document a meaningful review of DUEs at the Facility.<br><br>Summary<br>Review of compliance with Provision N7 indicated that the Facility did not have a functional DUE process in effect during the reporting period. Although the Facility updated its policy for DUE, there was no evidence to support implementation of the policy. The Facility's DUE practice must reflect its policy. For example, a DUE may have been developed for an ADR related to a prolonged QTc value, secondary to a prescribed medication. DUEs must be readily provided when other unusual and unexpected outcomes are noted at the Facility. Importantly, DUEs must be provided for all relevant FDA and/or Manufacturer advisories. Longitudinal data on DUEs should be collected for trends analysis. Educational venues should be developed for relevant staff, such as physicians, nurses, pharmacists and direct care providers on issues related to the DUE. 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 | To assess the Facility's ability to address medication variances, the Monitoring Team | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 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. | requested all medication variance reports completed during this review period, all related data, trends analysis, and list of action plans to address medication variances, as well as a copy of all training materials, and attendance sheets of training initiatives provided on medication variances. P&TC minutes, medication management workgroup meeting minutes, and the policy and procedure for the Facility's medication management workgroup were also requested. The clinical director informed the Monitoring Team of the Facility's recently established medication workgroup committee. This Committee meets at least twice per quarter, and then reports its findings on medication variances, ADR, and other medication related issue to the P&TC.<br><br>Medication management workgroup committee meeting minutes were not provided for review.<br><br>There was no trends analysis, summary, or recommendations medications provided by the pharmacy department, for this reporting period.<br><br>An updated policy and procedure was not provided for the Facility's updated medication variance practice.<br><br>Medication variance reports were provided for the fourth quarter of 2012, for both in-patient pharmacy, and ICF living area. The Monitoring Team noted a comprehensive data analysis of medication variances at the living area, that provide detailed analysis of all reported medication variances, including type of variance, location and shift that the variance occurred. Also included was a graph that represented medication variances over the past 12-month period. The report, however, did not include a summary, recommendations, or action steps on how to address medication variance. For example, during the reporting period, the Facility only reported six medication variances at the living area, and given the total number of medications administered it would be highly unlikely that only six medication variances occurred during this time frame; this should have been addressed to determine whether it might have indicated inaccurate data requiring retraining or other action to ensure all medication variances are reported. The medication variance report for inpatient pharmacy was as insightful as the living area report; however, it too was unaccompanied by a summary, and action plans to address medication variances. The Monitoring Team noted that there was a spike in medication variances per pharmacy for June and July 2012, but there was no summary explaining the spike. There was no data specific to physician prescribing variances, and there did not seem to be physician representation with regards to the medication variance process.<br><br>P&TC minutes for the August 28, 2012 P&TC meeting documented a review of the | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | medication variance reports, and noted the increase in pharmacy variances for June, and July 2012. The minutes reflected a brief explanation of the pharmacy spike in medication variances, and indicated that correction measures were implemented. The P&TC did not make any recommendations, to initiate an action plan or follow-up on the medication variance issue at the pharmacy.<br><br>Summary<br>The Monitoring Team was exceptionally pleased with improvements made by the Facility with regards to Provision N8, including the development and implementation of a medication workgroup, and its enhancement of the reporting and review process for medication variances, by developing a very useful graphing tool to capture medication variance data elements. This particular tool might be useful for consideration other facilities within the DADS system. The Facility is aware that it must continue to enhance its reporting and monitoring of medication variances, and must ensure that all relevant staff, including physicians, nurses, and pharmacists are provided regular in-services on the Facility's medication variance process. Importantly, physician service must participate in reporting on prescriber's variances. Also, a process for remediation of staff, and administrative action for repeated medication variances by staff, must be developed and implemented. The Monitoring Team would like to compliment all staff members who were involved with working towards compliance for Provision N8, and believes that if the Facility continues its improvements, it will achieve substantial compliance in the near future. | |

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

1. Ensure that labels used to document review of new medication orders include a verification area for necessary diagnostics. (Provision N1)
2. Ensure that all policies and procedures include the most recent date when the document was reviewed, and/or revised. (Provision N1 through N8)
3. Enhance the QDRR process, as delineated in the summary for Provision N2, of this report. (Provision N2)
4. Develop and implement a process to track, trend, and analyze the use of anticholinergics, benzodiazepines, polypharmacy, and STAT medications used as a chemical restraint. (Provision N3)
5. Physicians must document a meaningful clinical rationale and alternate action plan whenever the pharmacist's recommendations are not followed. (Provision N4)
6. The Facility must develop and implement a process that ensures robust monitoring, clinical assessment, reporting, and follow-up on all ADRs. All relevant staff including nurses, physicians, direct care staff, and pharmacists must be well trained on the Facility's ADR process. (Provision N6)
7. The Facility must enhance its DUE process to reflect recommendations made in Provision N.7, of this report. (Provision N7)
8. The Facility must maintain a schedule of all pending and completed DUEs, and ensure that the P&TC identifies at least four DUEs to be provided each year. (Provision N7)
9. Continue to improve the medication variance process, including development of a process for remediation of staff, and administrative action for repeated medication variances by staff, and participation by physician services. (Provision N8)
10. Ensure that there is a policy and procedure that clearly delineates the Facility's medication variance process. (Provision N8)

| SECTION O: Minimum Common Elements of Physical and Nutritional Management | |
|---|---|
| | **Steps Taken to Assess Compliance:**<br>1. RGSC Self Assessment (8/13/12)<br>2. RGSC Action Plan (8/9/12)<br>3. Physical and Nutritional Management Standard Operating Procedure ICF-MR 500 01 Rev 8/2012<br>4. Record reviews:<br>a. Sample 1: Individuals #26, #29, #35, #47, #60, and #79<br>b. Sample 2: Individuals #48, #51, #72, #97 and #126<br>c. Sample 3: Individuals #47, #79 and #126<br>d. Sample 4: Individuals #1, #55, #60, #62 and #76<br>5. A list of all therapy and/or clinical staff (OT, PT, SLP, RD), and Physical and Nutritional Management team (PNMT) members, including credentials<br>6. Minutes, including documentation of attendance, for the PNMT meetings since the previous compliance visit<br>7. Individual PNMT reports as available for individuals reviewed above<br>8. OT/PT assessments for individuals reviewed above<br>9. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order<br>10. A list of PNM assessments and updates completed in the last two (2) quarters<br>11. ISPs for the sample individuals<br>12. Completed Physical Nutritional Management Plans (PNMPs) for all sample individuals<br>13. Tools used to monitor implementation of PNM procedures and plans<br>14. For the past two quarters, any data or trend summaries used by the Facility related to PNM, and/or related quality assurance/enhancements reports, including subsequent corrective action plans<br>15. PNM spreadsheets generated by the Facility<br>16. Training records that occurred in response to diet downgrades<br>17. Lists of individuals:<br>a. On modified diets/thickened liquids;<br>b. Whose diets have been downgraded (changed to a modified texture or consistency) during the past 12 months;<br>c. With BMI equal to greater than 30;<br>d. With BMI equal to less than 20;<br>e. Since August 2011, people who have had unplanned weight loss of 10% or greater over six (6) months;<br>f. During the past 6 months, have had a choking incident;<br>g. During the past 6 months, have had a pneumonia incident;<br>h. During the past 6 months, have had skin breakdown; |

| | |
|---|---|
| | i. During the past 6 months, have had a fall;<br>j. During the past 6 months, have had a fecal impaction;<br>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.);<br>l. With poor oral hygiene; and<br>m. Who receive nutrition through non-oral methods<br>18. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation since the last review<br>19. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials<br>20. Tools and checklists used to provide competency-based training addressing:<br>a. Foundational skills in PNM; and<br>b. Individual PNM and Dining Plans<br>21. Since the last review, a list of competency-based training sessions addressing foundational skills in PNM<br>22. RGSC PNMT Monitoring Trend Report (1-2012 to 7-2012)<br>23. RGSC Alpha Monitoring List (1-2012 to 7-2012)<br>24. PNMT Action Plan Template<br>**People Interviewed:**<br>1. Jane Augustine PT Director of Habilitation Services<br>2. Belinda Lopez SLP<br>3. Pamela Hawxhurst OTR<br>4. Betty Perez Rehab Tech II<br>5. Marcy Valdez RN<br>6. Eight direct support professionals (3 La Paloma, 3 El Paisano, 2 Vocational Ed)<br>**Meeting Attended/Observations:**<br>1. PNMT meeting 8/28/2012<br>2. ISP for Individual #61<br>3. Vocational Education 8/28/2012 and 8/30/2012<br>4. La Paloma lunch and dinner<br>5. El Paisano lunch and dinner<br>6. Las Paloma and El Paisano transition times |
| | **Facility Self-Assessment:**<br>RGSC's Self-Assessment, updated 8/13/12 and Action Plan dated 8/9/12, provided comments/status for Sections O.1 through O.8 of the Settlement Agreement. The Self Assessment contained areas which were reviewed and/or analyzed to help gauge their level of compliance with the Settlement Agreement.<br><br>While the areas assessed were generally appropriate self-assessment activities, they were not the only ones that would be necessary to demonstrate substantial compliance in some cases and were complex elements to track effectively in others. The director, Jane Augustine, is commended for her approach to this process. |

| | |
|---|---|
| | The Self Assessment presented meaningful data in a useful manner that was clear and precise. However, the sample size was too small and the method in which the sample was chosen was too vague to be a reasonable representation of status or progress for a particular element.<br><br>The Facility self-rated itself as in noncompliance for Provisions O1 through O8. While actions taken were moving the Facility in a more positive direction, the Monitoring Team concurred with the findings of noncompliance for these elements. |
| | **Summary of Monitor's Assessment:**<br>Overall, RGSC appeared to moving in a positive direction with regards to providing physical and nutritional services. Improvement was evident with the PNMPs as they were noted be more comprehensive in addressing all areas in which physical and nutritional risk may be increased.<br><br>The PNMT met regularly, which was positive, but lacked evidence of clear analysis of the reason for referral as well as providing a clear framework for identifying the assessments needed to revise current plans of care and thus mitigating the risk associated with the referral.<br><br>The monitoring system remained informal and continued to focus heavily on mealtime with very little focus on areas outside of oral intake.<br><br>**Provision O.1:** This provision was determined to be not in compliance. Areas of need include increasing the timeliness in which the team responds to changes in status and the reassessment of individuals who have experienced a change in status.<br><br>Additionally, this provision is an overarching provision that covers multiple other issues outside of the PNMT. These areas include review of the PNMP, and development of the PNMP. These areas will be discussed in detail in Provision O.3.<br><br>**Provision O.2:** This provision was determined to be not in compliance. 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.<br><br>**Provision O.3:** This provision was determined to be not in compliance. PNMPs did not consistently contain detailed information regarding the need for elevation during check and change nor was there clear evidence of discussion of the PNMP as part of the ISP or in the event of a change in status.<br><br>**Provision O.4:** This provision was determined to be not in compliance. Staff was observed not implementing PNMPs or displaying safe practices that minimize the risk of PNM decline. Per interview, staff was not knowledgeable of the plans and why the proposed strategies were relevant to the individuals' well being.<br><br>**Provision O.5:** This provision was determined to be not in compliance. There was no process in place to |

| | |
|---|---|
| | ensure PNM supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual. 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.<br><br>**Provision O.6:** This provision was determined to be not in compliance. There was no evidence that staff or the individuals were being monitored in all aspects in which the individual was determined to be at increased risk. The primary focus of monitoring remained mealtime. Failure to provide monitoring in all aspects of PNM results in the individual being exposed to unnecessary risk. Reliability of the completed monitoring forms was also called into question due to significant discrepancy between the compliance rates noted in the forms and what was observed by the Monitoring Team as well as the methodology of scoring compliance on the forms.<br><br>**Provision O.7:** This provision was determined to be not in compliance. There was not a formal process in place that ensures individuals with increased PNM issues are provided with increased monitoring. At this time, this process is informal. Additionally there was not a process in place that represented a proactive approach to monitoring.<br><br>**Provision O.8:** This provision was determined to be not in compliance. All Individuals did not receive an annual assessment that addressed potential pathways to improved oral (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. |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| O1 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by | 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 (QDDP), Rehabilitation Tech (RT) and Food Service Manager. In addition to the listed core members, ancillary members such as medical may be requested as indicated. Members of the PNM team included:<br>1. Jane Augustine PT<br>2. Belinda Lopez SLP<br>3. Sotera Villalpando SLP<br>4. Pamela Hawxhurst OTR<br>5. Marcy Valdez RN<br>6. Carmen Phipps RD<br>7. Janie Villa QDDP Coordinator | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs. | 8. Vanessa Villarreal Psychology<br>9. Rosalva Ocegueda, Home Manager<br>10. Andrea Zuniga, Food Service Manager<br>11. Betty Perez, Rehab Tech II<br>12. Alondra Machado, QA<br>13. Vincenta Rocha, Administrative Assistant I<br><br>PNM Team attendance records and meeting minutes from 3/4/2012 to 7/20/2012 documented weekly meetings with sporadic attendance by PNM Team standing members.<br>• RN attended 15/19 (79%) meetings<br>• SLP attended 15/19 (79%) meetings<br>• OTR attended 13/19 (68%) meetings<br>• RD attended 18/19 (95%) meetings<br>• PT attended 18/19 (95%) meetings<br>• Psychology attended 18/19 (95%) meetings<br><br>The makeup of the PNMT was in compliance with standards set forth by the Settlement Agreement. Attendance by Psychology has shown an improvement since the previous compliance visit but participation by Speech and Occupational Therapy has declined. Staff who are unable to attend should have an assigned alternate who has been briefed on the issues that will be discussed at the meeting.<br><br>All PNMT members had received the necessary continuing education as required by their professional organizations as evidenced by all therapists having active licenses in the state of Texas.<br><br>The PNMT held meetings weekly with the focus of the meetings ranging from development or review of policy and procedures to comprehensive assessment if an individual was referred to the team by the IDT or if self referred.<br><br>Per review of six individuals hospitalized with aspiration pneumonia, only one of six (16%) was discussed at the PNMT meeting. For example:<br>• Individuals #60 and #79 were diagnosed with pneumonia on 2/27/2012 but there was no evidence of review, assessment or discussion by the PNMT or IDT.<br><br>An additional concern, as in previous visits, was the lack of detailed discussion regarding the onset of the event as well as details regarding steps to mitigate future risk.<br><br>The PNMT RN, Marcy Valdez, attended the morning medical meetings. Participation in | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | this meeting was to result in improvement in the ability to identify issues occurring throughout the Facility, but as stated above, there remained a lack of consistent discussion.<br><br>The PNMT had begun to utilize an action plan template as part of the PNMT weekly meetings. This template would allow for greater organization and tracking as it clearly identified the PNM objectives, action steps, person responsible, and the timeline for completion of the assigned task. The development of the form will assist the PNMT in better being able to track all services and ensure they are completed in a timely manner.<br><br>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. This was an area that RGSC was aware of and working towards resolving the issue. Per observation of an ISP for Individual #61, there was much improved discussion and collaboration between team members. Part of the improved discussion focused on review of the PNMP.<br><br>Clinical indicators in which referral back to the PNMT would be required was not clearly implemented as part of the PNMT review or evaluation process. Examples of clinical indicators may be weight loss below or above a desired threshold, or occurrence of triggers. Identification of these thresholds would allow the PNMT to discharge individuals once stabilized and in turn focus more resources on those in more immediate need.<br><br>There were also issues noted with the current method of PNM documentation. The Clinical Work Station (CWS) Integrated Progress Notes (IPNs) was intended to be the primary location of progress notes but these were not utilized accordingly. PNMT meetings, mealtime observations, and assessments were not consistently referenced as part of the IPNs. Lack of consistency in utilizing the IPNs to track meetings, observations, and assessments results in a decreased ability of other professionals to follow the complete plan of care. Lack of documentation and follow up were a pervasive issue and will be discussed further in Provision M5 in relation to aspiration triggers. | |
| 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 | 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 six individuals who accounted for 83% of the individuals who experienced pneumonia or choking event.<br><br>Sample #2 consisted of five individuals who were chosen from a list provided by RGSC of individuals who were identified as being at an increased risk of aspiration. The sample accounted for 55% of individuals who were at an increased aspiration risk. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems. | Sample #3 consisted of four individuals, which accounted for 100% who received enteral nutrition.<br><br>Sample #4 consisted of five individuals which accounted for 19% who had a diet downgrade during the previous 12 months.<br><br>Based on a review of 11 individuals' OT/PT assessments and PNMT evaluations (Sample #1, and #2), four of 11 Individuals (36%) were provided with a comprehensive assessment by the PNM team or IDT 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. Missing from the PNMT assessments were consistent review and assessment to determine etiology of changes in status. Missing from the OT/PT assessments were comparative analysis of current vs. previous status.<br><br>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:<br>• Individual #47's oral motor section stated only that he receives nutrition via peg but did not provide any more information regarding oral status.<br>• Individual 26's medication administration section stated, "crush medication and place in applesauce" but there was no evidence of assessment.<br><br>A comprehensive PNMT evaluation had been developed and approved by DADS central office. The PNMT in its format appeared to be comprehensive in that it covered:<br>• Risk factors<br>• Medication side effects<br>• Oral motor assessment<br>• Nutritional indicators<br>• GI issues<br>• Review of past assessments<br>• Hospitalizations<br>• Surgical procedures<br>• Physical assessment<br>• PNM analysis and recommendations<br><br>Missing from the assessments were criteria for referral to the PNMT and evidence that strategies listed in the PNMP were re assessed for appropriateness.<br><br>As stated earlier in Provision O.2, there was limited investigation or assessment as it | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | related to the etiology of the pneumonia diagnosis. The PNMT assessment as well as the OT/PT assessment did a much better job than in previous compliance visits in identifying past medical history and current active problems but lacked in documented ability to problem solve and develop clear plans of action.<br><br>Based on a review of six (Sample #1) records of Individuals who were diagnosed with pneumonia and/or choking, four of six (66%) were noted by the Facility to be at an increased risk of aspiration and zero of six (0%) had their risk ratings reviewed upon a change in status, which in this case was pneumonia.<br><br>Examples of individuals not being appropriately identified include:<br>• Individuals #35 and #26 were both diagnosed with pneumonia but were not identified as being high risk.<br>• Individual #60 was diagnosed with pneumonia on 2/27/2012 but did not have the risk rating reviewed by the Interdisciplinary Team (IDT) upon confirmation of diagnosis.<br><br>One out of five (20%) individuals who were diagnosed with pneumonia and/or choking (Sample #1) was assessed or comprehensively discussed by the PNMT or IDT. For example:<br>• Individual #60 was diagnosed with pneumonia on 2/27/2012 but there was no evidence of comprehensive assessment or review by the PNMT or IDT.<br>• Individual #79 was diagnosed with aspiration pneumonia on 4/13/2012 but there was no evidence of reassessment or discussion of the event by the IDT pr PNMT.<br><br>Two of five Individuals (40%) who had diet downgrades were discussed by the IDT. (Sample #4). For example:<br>• Individuals #1, #60, and #62, all had their diets downgraded but there was no discussion or evidence of notification to the IDT.<br><br>Per interview with the PNMT, it was noted that most referrals were reviews initiated by the PNMT post hospitalization and very seldom if at all do they receive a request of consultation from the IDT. This approach is very reactive and did not appear to proactively identify concerns prior to them having a significant negative impact on the individual.<br><br>A PNMT referral form was submitted to the Monitoring Team but as stated previously, the form was not being used at RGSC as all referrals were self initiated and therefore did not have the need to utilize the form. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | A positive noted was the ordering and utilization of adjustable tables in the dining areas. The ability to raise and lower the tables appeared to assist staff in better being able to position the individuals for increased safety during intake. | |
| O3 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties. | All persons identified as being at risk (requiring PNM supports) were provided with a Physical and Nutritional Management Plan (PNMP); however, the plans were not comprehensive as information regarding oral care and medication administration was lacking the detail needed to ensure safe consistent delivery of service. This included lack of staff positioning, and information regarding texture or consistency of liquids or medications as well as use of adaptive equipment.<br><br>The PNMPs for the 11 individuals in Samples #1 and #2 were reviewed. All of these individuals had a PNMP. However, the plan lacked the comprehensiveness needed to ensure consistent implementation:<br>• Eleven of the 11 individuals (100%) had a PNMP.<br>• Eleven of the 11 individuals PNMPs (100%) were current within the last 12 months<br>• Nine of the 11 individuals PNMPs (81%) noted individual-specific risks and related triggers.<br>• In 11 of 11 individuals' records (100%), the PNMPs included adequate positioning instructions for wheelchair and alternate positioning, including strategies for safe elevation ranges.<br>• In 11 of 11 individuals' records (100%), the PNMPs included adequate transfer instructions.<br>• In 11 of 11 individuals' records (100%), the PNMPs included adequate mealtime/dining plans that included written and/or pictorial instructions for positioning, food texture, fluid consistency, and/or staff presentation techniques.<br>• In 9 of 11 individuals' records (81%), the PNMP included the time an individual needed to remain upright after eating and/or receiving enteral nutrition.<br>• In six of 11 individuals' records (54%), the PNMPs included adequate strategies for oral hygiene.<br>• In 11 of 11 individuals' records (100%), the PNMPs included a listing of individual adaptive equipment.<br>• In 11 of 11 individuals' records (100%), the PNMPs included adequate bathing/showering positioning and related instructions.<br>• In 11 of 11 individuals' records (100%), the PNMPs included basic information regarding the individuals' level of communication.<br><br>Per the Habilitation Therapy Director, the dining plans had been replaced by the PNMP. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | This change was initiated in an effort to improve consistency of implementation by removing the dining plan and thus having a single plan of care.<br><br>Based on a review of an identified sample of 11 individual records (Samples #1, and #2) PNMPs were not formally developed with input from the IDT. In zero of 11 records reviewed (0%), PNMPs were clearly developed with input from the IDT with an emphasis on direct support professionals (DSPs0, medical/nursing staff, and behavioral staff (if appropriate). Per record review, there was evidence in the ISPs 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. Review of the 11 individuals' ISP attendance sheets in Samples #1 and #2 found:<br>• Occupational Therapist attendance was 27% (three of 11 meetings);<br>• Physical Therapist attendance was 36% (four of 11 meetings):<br>• Speech Language Pathologist attendance was 91% (10 of 11 meetings);<br>• Registered Dietician attendance was 54% (6 of 11 meetings); and<br>• Direct support professional attendance was 54% (6 of 11 meetings).<br><br>The absence of these professionals impacted the discussion related to the integration of PNMP into the ISP, risk assessment, and multiple support plans. In addition, the absence of dental staff and direct support professionals impacted the ability of the IDT to adequately review and integrate an individual's PNMP into the ISP. Direct support professionals are responsible for the implementation of PNMPs. Their significant contribution to the content of a PNMP should not be underestimated. Having a direct support professional in attendance with a strong relationship with an individual and who has provided support to the individual would provide invaluable information. These professionals have knowledge regarding how an individual responds to activities in their daily routines.<br><br>For example, a direct support professional would be able to help the team define how an individual who cannot verbally communicate expresses their discomfort or shows physical signs that might indicate the onset of an illness. This information should be integrated with the triggers on the individual's PNMP. In addition, direct support professionals should have the opportunity to discuss PNMP strategies that might not be effective and/or request clarification on how to implement a strategy. This should lead to a dynamic discussion resulting in acceptance and/or revision of the proposed PNMP strategies.<br><br>PNMPs were located in the record, All about Me Individual Notebooks, and in the dining room. Additional copies are located at Voc Ed in the Master Binder. Per observations, "All About Me" books were readily available to staff but were not being referenced during | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | any of the observations. | |
| 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 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. At no time during any of the observations was staff observed referring to the PNMPs outside of mealtime. In most cases, pictures were available with the PNMPs. Pictures related to wheelchair and bed positioning, and the use of orthotics or braces were now included as part of the PNMP.<br><br>Four mealtime observations (2 lunches and 2 dinners) demonstrated that staff did not implement interventions and recommendations outlined in the PNMPs that were most likely to prevent swallowing difficulties and/or increased risk of aspiration. In only 13 of 21 (61%) observations, staff were following PNMPs. Although there was still much work, much improvement in staff implementation of these plans was noted since the previous visit which indicated an implementation rate of less than thirty percent.<br><br>Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan included:<br>• Individual #15 was not provided with cues to take small bites and sips and was observed not receiving cues to swallow multiple times post each bite or slow down intake. This individual ate his entire meal in less than 30 seconds resulting in placing the individual at an unnecessary risk.<br>• Individuals #21, #67, #74, and #96, were observed taking large bites when the plans called for small bites, thus increasing their risk of choking and/or aspiration.<br><br>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 eight DSPs, percentage of correct responses regarding PNMPs were:<br>• Where is the PNMP located? (100%)<br>• What kind of transfer do they require? (100%)<br>• What do you look for to ensure the individual is in the correct position? (37%)<br>• Why does the individual need thickened liquids? (87%)<br>• Why does individual eat modified texture foods? (75%)<br>• Why does the individual require a specific utensil? (75%)<br>• Why does the individual require a specific assistance technique? (50%)<br>• What are the individual's risk indicators? What do you look for before, during and after the meal? (50%) | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • Does the individual have an Aspiration Trigger Data Sheet, where is it kept and when do you document? (37%)<br>• Have you been trained to implement this plan? (60%)<br>• Who do you contact if you have difficulty with the plan or the equipment? (75%)<br><br>While much work still needs to be done regarding staff knowledge, this did represent an improvement since the previous compliance visit. | |
| O5 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing. | DSPs 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:<br>• Dining<br>• Adaptive feeding equipment<br>• Adaptive equipment (gait belt, lift vest, orthotics, bathing, and range of motion)<br>• Dysphagia<br><br>Evidence of skills based or competency based training was present for PNMP, Lift Vest, Support Station, Communication, Hearing Aid Use and Dysphagia and that was in the form of a general questionnaire. There was no evidence of return demonstration or testing that focused on areas related to PNM or individual specific competency training outside of texture of foods and consistency of liquids.<br><br>Per the SLP, annual refreshers had not been consistently provided to staff.<br><br>Nursing staff were primarily comprised of contract staff and there was lack of evidence showing that nurses had participated in the PNM training provided by Habilitation Therapies.<br><br>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.<br><br>Per review of training records for Sample #4 individuals that occurred in response to downgrades in diet, for zero of five (0%) there was evidence of staff training regarding the change in care which in this case focused on the texture downgrade.<br><br>Per the Self Assessment dated 8/13/12 and interview with the PNMT Chair and Habilitation Director, RGSC did not have the data needed to determine if staff had received competency based training. A system was in the process of being developed to assist with the documentation of individual specific training. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | | |
| 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.<br><br>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.<br><br>While the forms were designed to address mealtime and other PNM areas and had multiple professionals involved, a policy or process was not fully developed that included:<br>• Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk,<br>• 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,<br>• Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician, and<br>• Monitoring schedule based upon level of risk.<br><br>Per review of the PNMT minutes (February 2012 to July 2012), monitoring was discussed during the meetings but analysis of findings as well as the trending of data remained limited.<br><br>Monitoring reports only provided information regarding total compliance and number of monitoring forms completed by staff. The reports did not provide clear information and data regarding specific indicators within the monitoring form. Examples of this would be percentage of monitors in which staff could identify triggers or percentage in which staff implemented the PNMP.<br><br>Per monitoring trend report provided by RGSC for the months of January 2012 to July 2012, 175 monitors were completed for 39 individuals utilizing the comprehensive monitoring form.<br><br>A review of PNMT monitoring list from January 2012 to July 2012 documented that staff were not being monitored in all aspects in which the individual was determined to be at | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | increased risk. Monitoring continued to focus primarily on mealtimes. Per review:<br>• 87 of 175 (49%) monitoring forms focused on oral intake (meals and snacks)<br>• 7 of 175 (4%) monitoring forms focused on bathing<br>• 24 of 175 (13%) monitoring forms focused on medication administration<br>• 24 of 175 (13%) monitoring forms focused on oral care.<br>• 21 of 175 (12%) monitoring forms focused on positioning.<br>• 12 of 175 (6%) monitoring forms focused on lifting/transfers and orthotics<br><br>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. Due to this scoring issue, data suggesting high compliance was potentially inaccurate.<br><br>Additionally, 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.<br><br>As stated, the frequency of monitors appear to be sufficient but the ratio of the monitors did not cover all the areas needed as evidenced by the large number of meal monitors in comparison to the oral care, medication administration, and bathing. Monitoring in areas outside of mealtime is essential to reducing the risk of pneumonia and aspiration. More time should be spent providing monitoring to areas such as positioning and medication administration to ensure proper technique and consistency of care.<br><br>An Aspiration Trigger Sheet has been in place since 1/26/12. Per review, the trigger sheets were provided to individuals who were identified as being at a moderate or high risk. Issues noted with the Aspiration Trigger Sheet included:<br>• 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.<br>• Lack of consistent and detailed documentation surrounding the occurrence of triggers (e.g., activity in which trigger occurred, positioning of the individual)<br>• Lack of consistent completion by staff (missing data points)<br>• Lack of review by the RN Case Manager<br>• Aspiration Trigger sheets did not follow the person and were not readily available for staff to document the occurrence or absence of triggers. At the time of the review, the Aspiration Trigger Sheet was located at the home in the supervisor's notebook away from where the individual was located. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | | |
| 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 14 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.<br><br>While PNMPs are reviewed at the 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 are determined to be at an increased risk such as the occurrence or absence of triggers (signs and symptoms associated with physical and nutritional decline that require staff response).<br><br>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 status. For more information please see Provision O.2.<br><br>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, skin breakdown, choking, or aspiration for an individual effectively resulted in a reduction from the previous period. There was no detailed comparative analysis of data or assessment findings. Outcomes were reviewed through the risk process but effectiveness of strategies was not.<br><br>There was no system in place that allowed for the overall tracking and trending of the monitoring data. A system did accumulate the data but did not provide information regarding the difference between effectiveness of the plans and staff implementation of the plans. The data that was able to be acquired only answered the level of overall compliance (e.g., a score of 80% or higher or 8 out of ten probes correctly responded to) and did not provide data regarding what areas of compliance were not achieved. | Noncompliance |
| O8 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically | The following section was based on three (100%) individuals who received enteral nutrition (Sample 3).<br><br>The Aspiration Pneumonia/Enteral Nutrition Evaluation (APEN) was to be completed in the event an individual was diagnosed with aspiration pneumonia or if the individual received enteral nutrition. The purpose for those who received enteral nutrition in receiving an APEN was to guide the team in determining not only the medical necessity of the current form of nutrition but to identify potential methods or pathways to resume | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding. | oral intake or the last restrictive form of nutrition.<br><br>There were three individuals listed as receiving enteral nutrition. Enteral evaluations for individuals for all enterally fed individuals were requested by the Monitoring Team.<br><br>All individuals who were enterally fed (Sample #3) received an APEN, but upon review, the APEN did not 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 (for example., Seroquel and Haldol) and its potential impact on swallowing. 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 #47. This individual's APEN included information on fractures which were not clearly linked to the increased risk of aspiration or return to oral intake.<br><br>The three individuals had received a Habilitation Therapy (Bedside Swallow) assessment but content lacked analysis regarding potential pathways to improved oral (PO) status. While three of three (100%) assessments included why the tube was medically necessary, zero out of three assessments for those individuals who were non-oral intake (NPO) identified a clear pathway to oral intake. The section titled "Attempts to Return to Oral or Least Restrictive Method of Eating" focused primarily on a bedside swallow evaluation and if the person was presently able to begin oral intake. Missing from the section was identification of ways to improve oral musculature in an effort to not only moving the person towards potential oral intake but to improve oral musculature. Based upon review, individual trials of intake or a MBSS were the only method attempted by RGSC to increase oral intake.<br><br>Another concern was there was a lack of team completion of the APEN. Per review of the three APENS, zero of three (0%) were completed by all responsible parties. Missing from the APEN was evidence of consistent participation by the PCP, Pharmacist, Nurse Case manager, Habilitation Therapist, and PNMT Nurse.<br><br>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.<br><br>All individuals who received non-oral intake (NPO) in the selected sample had been provided a PNMP that included the same elements described above in Provision O.3. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | The need for continued enteral nutrition was not consistently integrated into the PSP. Based on a review of three individuals' PSPs, for one of three individuals who received enteral nutrition (33%), the individual's PSP clearly documented the rationale for the continued need for enteral nutrition. | |

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

1. Improve analysis as well as documentation of analysis provided by the PNMT in response to a hospitalization. (Provision O.1)
2. Utilize Avatar CWS to document PNMT, SLP, and OT, PT assessments, observations and discussions. (Provision O.1)
3. Improve attendance percentages of PNMT members at the weekly meeting. If a member is going to be absent, then an alternate should be identified and information shared prior to meeting. (Provision O.1)
4. Utilize the clinical record to document actions and discussions taken by the PNMT. (Provision O.1)
5. A formal process should be developed that ensures individuals who are at an increased risk receive more intensive monitoring during the activities in which their risk is increased. Include a mechanism to document recommendations for follow-up and a means to document closure on issues identified. This often works well when this is included on the form used to monitor. (Provision O.6)
6. The monitoring policy for mealtime and PNMP monitoring should describe a monitoring system that includes criteria for, and identification of, who will complete the monitoring, competency-based training for monitors, descriptions of each indicator with monitoring strategy, definition of staff retraining thresholds, a validation/inter-rater reliability process, the use of monitoring reports to assist in the identification of problematic issues and/or trends, the formulation of corrective strategies to address areas of deficiency, and integration of the monitoring system into facility Risk Management and Quality Assurance systems. (Provision O.6)
7. The Aspiration Trigger sheet should be readily available to staff to document the occurrence or absence of triggers at the time of the event and not at the end of a shift. (Provision O.6)
8. The monitoring form should be reviewed and revised to improve accuracy of compliance data. (Provision O.6)
9. A monitoring schedule should be developed that is based upon risk with those who are at the highest level receiving the most intensive frequency of monitoring. (Provision O.6)
10. 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)
11. 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)
12. APENs should be reviewed and revised as indicated by a change in status so that they contain the most recent and relevant information. (Provision O.8)

The following are offered as additional suggestions to the Facility:

1. RGSC would benefit from increased peer to peer consultation to improve overall knowledge base of clinicians regarding PNM related assessments and processes.
2. The designation of staff whose responsibility is to ensure PNMPs are implemented correctly and consistently would greatly assist RGSC in reducing implementation issues as well as assist with staff training. This could be the development of a PNM coordinator position or utilization of existing senior staff.

| 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:**<br>**Documents Reviewed:**<br>1. RGSC Self Assessment (8/13/12)<br>2. RGSC Action Plan (8/9/12)<br>3. Physical and Nutritional Management Standard Operating Procedure ICF-MR 500 01 Rev 8/2012<br>4. RGSC OT/PT Standard Operating Procedure MR700 06 (January 2010)<br>5. Record reviews:<br>a. Sample #1: Individuals #26, #29, #35, #47, #60, and #79<br>b. Sample #2: Individuals #48, #51, #72, #97 and #126<br>c. Sample #3: Individuals #1, #81, #86, #134, and #140<br>d. Sample #4: Individuals #8, #46, and #118<br>e. Sample #5: Individuals #24, #81, and #132<br>6. Current Lists of people:<br>a. Who use wheelchair as primary mobility;<br>b. With transport wheelchairs;<br>c. With other ambulation assistive devices, including the name of the device;<br>d. With orthotics and/or braces;<br>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.<br>f. Who have experienced a falling incident during the past three (3) months, including name of individual, date, location, whether there was injury, and, if so, type of injury.<br>7. 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<br>8. List of individuals receiving direct OT and/or PT services and focus of intervention<br>**People Interviewed:**<br>1. Jane Augustine PT Director of Habilitation Services<br>2. Pamela Hawxhurst OTR<br>3. Betty Perez Rehab Tech II<br>4. Irma Garcia, Job Requisition Coordinator<br>5. Eight direct care staff (3 La Paloma, 3 El Paisano, 3 Vocational Education)<br>**Meeting Attended/Observations:**<br>1. PNMT meeting 8/28/2012<br>2. ISP for Individual #61<br>3. Vocational Education 8/28/2012 and 8/30/2012<br>4. La Paloma lunch and dinner<br>5. El Paisano lunch and dinner<br>6. Las Paloma and El Paisano transition times |
| | **Facility Self-Assessment:** |

| | |
|---|---|
| | RGSC's Self-Assessment, updated 8/13/2012 and Action Plan dated 8/9/12, 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.<br><br>For the self-assessment, the Facility described, for each provision item, the activities the Facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process.<br><br>Overall, the Self Assessment and Action Plans included relevant steps that would assist in the state in gaining compliance; however, the activities at times were not consistently in line with what the monitoring team assesses as indicated in this report. Examples of this occurring included:<br>▪ The Facility's Self-Assessment did not define how the samples were selected.<br>▪ Not all requirements of the Settlement Agreement had been reviewed. More specifically, within a sub-section, the Settlement Agreement might have numerous requirements, but only some were included in the Facility's Self-Assessment<br><br>Overall, the Facility had demonstrated some good use of the data it had collected. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed. |
| | **Summary of Monitor's Assessment:**<br>Overall, improvement was noted with the comprehensiveness of the OT/PT assessments as well as with staff implementation of the PNMPs. Assessments still require additional work to be considered comprehensive as information regarding community placement, schedule for monitoring as well as comparative analysis remained lacking.<br><br>Additionally, a system must also be developed that will ensure all individuals are provided with a level of monitoring that covers all areas in which their risk may be increased and one that provides increased monitoring for those who require the greatest assistance.<br><br>**Provision P.1:** This provision was determined to be not in compliance. Assessments were completed in accordance to the schedule set forth by RGSC; however, assessments were not being consistently completed in response to a change in status and were not comprehensive. Additionally, assessments were not consistently provided in time for them to be utilized in the planning of the ISP.<br><br>**Provision P.2:** This provision was determined to be not in compliance. Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. Other than the limited evidence of direct intervention, the primary support provided was via the PNMPs. Additionally, therapy services were not consistently integrated into the ISP and staff still did not consistently implement interventions and recommendations outlined in the PNMP |

| | |
|---|---|
| | **Provision P.3:** This provision was determined to be not in compliance. Staff were also not knowledgeable of the plans that were to be implemented. There was also not a clear process that ensured staff was provided with individualized training prior to working with individuals who were identified as being at an increased risk of aspiration.<br><br>**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:<br>• Definition of monitoring process<br>• Formal schedule for monitoring to occur<br>• Monitors are re-validated on an annual basis by therapists and/or assistants<br>• Results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| P1 | By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner. | 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 six individuals who accounted for 83% of the individuals who experienced pneumonia or choking event.<br><br>Sample #2 consisted of five individuals who were chosen from a list provided by RGSC of individuals who were identified as being at an increased risk of aspiration. The sample accounted for 55% of individuals who were at an increased aspiration risk.<br><br>Sample #3 consisted of the 5 individuals who were provided the most recent OT/PT assessments.<br><br>Sample #4 consisted of three individuals who experienced the highest number of falls over the past 6 months.<br><br>Sample #5 consisted of three individuals who were admitted since the last compliance review.<br><br>The Facility did not provide an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience. There was one contract Occupational Therapist (OT), two Physical Therapist (PTs), and one Physical Therapy Assistant (PTA). Per the Job Requisition Coordinator, all positions were filled and in reality RGSC at full staffing would only consist of two SLPs and one PT. All other positions such as PTAs, and OTs were positions that were provided in addition to full staffing. This was of concern to the | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Monitoring Team as there was a need to not only maintain the current staffing levels but to expand the hours of occupational therapy in an effort to provide the needed services.<br><br>As mentioned, the OT was contract and was only available for 24 hours per week. The Physical Therapist had a full caseload as well as duties as the Director of Habilitation Therapies and PNMT Chair. The PTA accounted for a total of 6 hours per week. The additional PT focused primarily on lifting/transfers.<br><br>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 individuals who did not have established PNM needs would likely require occasional supports to address acute injuries or to address more chronic conditions associated with aging. Many others would likely benefit from skill acquisition/enhancement programs related to movement and mobility, as well as fine motor skills and independence. This level of supports and services could not be adequately met with the current staffing levels for PT. Current utilization of the OT did not appear to be appropriate to adequately address individual needs beyond those primarily related to the PNMP.<br><br>At the time of this review, the census at RGSC was 70 individuals. The reported number of individuals with PNM needs was 70 or 100% of the total census. The assistants were not licensed to complete assessments and design interventions supports and, as such, were not included in these ratio calculations. The ratios based on the current census were approximately 1:70 (PT) and 1:70 (OT). As mentioned previously, the PT had multiple other duties outside of the regular scope of practice and the OT was contract and was only available as part time.<br><br>At the time of this onsite review Jane Augustine PT continued to serve as the Habilitation Therapies Department Director as well as a member of the PNMT. OT/PT staffing was generally consistent with the previous review. Physical therapy included Jane Augustine PT (who also served as director and PNMT lead), Rose Bazan PT and Kevin Belsole PTA. Occupational Therapy included Pamela Hawxurst OTR.<br><br>The Facility did document appropriate qualifications for licensed OTs and PTs.<br>Four of 4 staff (100%) were licensed to practice in the state of Texas.<br><br>No evidence was provided of continuing education completed since the last compliance review; however, all OT, PT, and PTAs had received the necessary continuing education as required by their professional organizations as evidenced by all therapists having | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | active licenses in the state of Texas.<br><br>A new comprehensive assessment format was in use at the Facility and included assessment by OT and PT. The outline submitted included medical history, medications, behavioral concerns, and other current health issues that would impact the delivery of OT and PT services. The assessment included physical assessment of sensory/motor/neuromuscular systems and functional motor and daily living skills performance. Physical Nutritional Management issues related to positioning supports, mealtime, medication administration, and oral care were also addressed. The outline also included sections to address the clinicians' analysis of findings (summary, strengths and needs), recommendations, measurable outcomes, interval for reassessment, and factors for community placement.<br><br>Therapists were instructed to analyze the clinical information as each section was completed so that reasoning was not lost. Skill acquisition and functional activities were to be considered throughout the assessment process. Functional and measurable objectives were to be outlined as indicated.<br><br>The comprehensive assessment was to be completed within 30 days of admission and an update was to be completed at least annually to address services provided to the individual during the past year. A comprehensive assessment of specific systems and related areas was to occur upon a change in health status. A schedule for re-assessment was to be included in the written report.<br><br>Generally accepted standards of a comprehensive assessment include the following:<br>• Signed and dated by the clinician upon completion of the written report<br>• Dated as completed 10 days prior to the annual ISP<br>• Diagnoses and relevance to functional status<br>• Individual preferences, strengths, interests, likes, and dislikes<br>• Medical history and relevance to functional status<br>• Health status over the last year<br>• Medications and potential side effects relevant to functional status<br>• Documentation of how the individual's risk levels impact their performance of functional skills<br>• Functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day.<br>• Evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work)<br>• Discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • Discussion of the expansion of the individual's current abilities<br>• Discussion of the individual's potential to develop new functional skills<br>• Comparative analysis of health and impact on functional status over the last year<br>• Comparative analysis of current functional motor and activities of daily living skills with previous assessments<br>• Identify need for direct or indirect OT and/or PT services<br>• Reassessment schedule<br>• Monitoring schedule<br>• Recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs<br>• Factors for community placement and a determination of the most appropriate living environment<br>• Recommendations for services and supports in the community<br>• Manner in which strategies, interventions, and programs should be utilized throughout the day.<br><br>The total number of assessments reviewed was 22 (Samples #1, #2, #3, #4, and #5). Comments are below:<br>• 54% (12/22) were identified as comprehensive assessments. Evaluations did not contain clear comparative analysis, community placement information, or a clear schedule for future monitoring based upon risk.<br>• 100% (22/22) were signed copies of the original, Assessments had dated signatures.<br>• 59% (13/22) of the assessments were dated as completed ten days prior to the annual ISP meeting. Failure to provide assessments prior to the ISP inhibits the team's ability to properly plan and address areas of need.<br>• 86% (19/22) included a section that reported health risk levels that were associated with PNM supports. This information was generally utilized for planning interventions and supports and for recommendations related to changes in the existing risk levels.<br>• 90% (20/22) included an analysis section which provided a sufficient rationale for current interventions and supports.<br>• 9% (2/22) included a monitoring schedule. The frequency of PNMP monitoring was not identified. The level of health risk was not clearly used to drive the frequency of monitoring for individual status, effectiveness of supports and interventions, or implementation of the PNMP.<br>• 100% (22/22) included a re-assessment schedule.<br>• 0% (0/22) included supports required for placement in a community setting. Limited to no information was provided under the section "Community | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Placement" regarding the need for future assessments, home adaption/modification or need for staff training prior to placement.<br>• 100% (22/22) included evidence that communication and or collaboration was present between the OT and PT in the OT/PT assessments.<br>• For the ISPs:<br>o 100% (22/22) of the ISP/PSPs submitted were current within the last 12 months.<br>o 18% (4/22) of the current ISPs with signature pages submitted were attended by OT only. No PTs attended these meetings.<br>o 50% (11/22) of the current ISPs with signature pages submitted were attended by PT only. No OTs attended these meetings.<br>o 0% (0/22) of the current ISPs with signature pages submitted were attended by both the OT and PT.<br>o 31% (7/22) of the current ISPs with signature pages submitted were attended by neither the OT nor PT.<br><br>Although there is no requirement that both an OT and PT attend an ISP planning meeting, and often only one would be expected depending on the needs and preferences of the individual, the Monitoring Team is concerned that neither was present at 31% of ISP planning meetings when Samples 1, 2, and 4 consisted of individuals with a demonstrated need for such clinician's participation, and Sample 4 was newly admitted individuals for whom review from such clinicians is generally very valuable (totaling 17 individuals, 78% of the 22 reviewed).<br><br>It is recommended that RGSCC review this policy and or procedure to ensure all areas of expertise are present at the meetings as needed.<br><br>As indicated above, the assessments were found not to have all components needed to be considered comprehensive and were not provided to the QDDP in a timely manner.. The majority of assessments were not comprehensive due to lack of information regarding community placement, and lack of comparative analysis with previous assessments.<br><br>There were three individuals newly admitted to the Facility (Sample #5) since the last onsite review. Three of three individuals (100%) received the required OT/PT assessments within 30 days of admission but only one of three (33%) assessments were provided in a timely manner to the QDDP. | |
| P2 | Within 30 days of the integrated occupational and physical therapy assessment the Facility shall | Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. Please refer to Provision O.2 regarding assessments in response to a change in status. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression. | Intervention plans related to positioning were based on findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies. As noted in Provision P.1, most assessments included rationales for interventions and supports.<br><br>Based on reviews of PNMPs and other positioning plans for 22 individuals (Sample #1, #2, #3, #4, and #5) equipment was specified for 22 of 22 (100%) plans reviewed.<br><br>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 little to no evidence that the majority of plans were reviewed by the IDT related to program changes or changes in status; the IDTs should have reviewed when there was a significant change in status. Examples were Individuals #8, #46, and #118 who experienced multiple falls over the past six months without evidence of review by the IDT.<br><br>Only ten individuals were noted to receive restorative or direct PT services that focused on ambulation and the use of adaptive equipment. More individuals would likely benefit from direct services as evident by the number of 98 falls that were noted to have occurred since the last compliance visit by RGSC.<br><br>Other than the evidence of this restorative and direct intervention, the primary support provided was via the PNMPs. PNMPs and Skill Acquisition Program (SAPs) addressed areas related to positioning, transfers, handling, and mobility, but interventions were limited when related to promoting independence and skill acquisition. PT intervention was generally designed to address gait, ambulation, and transfers and range of motion. OT intervention was designed to promote range of motion or to provide splints. The interventions in place were well documented and had established measurable and functional goals. It should be noted that OT was in the process of developing programs that were more focused on the acquisition of skills needed to become more independent and therefore improve the likelihood of potential placement.<br><br>Justification for continued therapy or discharge was clearly provided. Programs and interventions for other skill acquisition were not identified as a need and, as such, were not provided.<br><br>The PNMP addressed use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment.<br>• Based on reviews of PNMPs and other positioning plans for 22 individuals (Sample #1, #2, #3, #4, and #5) the rationale for the plans were clearly stated in the OT/PT assessment or update for 90% (20/22) individuals. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • Assessments clearly stated that the PNMPs should be followed as well as stating the function of the device.<br><br>While much improved since the previous compliance visit, staff still did not consistently implement interventions and recommendations outlined in the PNMP. See Provision O.4 for information. | |
| 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. | Competency-based training for, and monitoring of, continued competency and compliance of direct support staff related to implementation of PNMPs was addressed in detail in Provision O.4 and O.5.<br><br>Equipment generally was available but implementation by staff was not consistently performed as intended per the PNMP or per the generally accepted professional standards of care. For examples, please refer to Provision O.4.<br><br>Staff were also not knowledgeable of the plans that were to be implemented. Examples of this are included in Provision O.4.<br><br>As stated in Provision O.5, staff were provided initially with general competency-based foundational training related to aspects of PNM by the relevant clinical staff. There was no single comprehensive course that covered all aspects of OT/PT related care provided outside of the Basic Care Class. Review of the Facility's training curricula revealed PNM training in the following areas:<br>• Dining plan<br>• Adaptive feeding equipment<br>• Adaptive equipment (gait belt, lift vest, orthotics, bathing, and range of motion)<br>• Dysphagia<br><br>Evidence of skills based or competency based training was present for PNMP, Lift Vest, Support Station, Communication, Hearing Aid Use and Dysphagia and that was in the form of a general questionnaire. There was no evidence of return demonstration or testing that focused on areas related to PNM outside of mealtime texture and consistency or individual specific competency training.<br><br>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. | Noncompliance |
| P4 | Commencing within six months of the Effective Date hereof and with | A system of monitoring of the PNMPs, and the condition, availability, and effectiveness of physical supports and adaptive equipment was not fully implemented at RGSC and | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 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. | addressed in Section O above. Recommended frequency of monitoring was not included in the OT/PT assessments or as part of a greater PNM or OT/PT policy or procedure. Frequency or interval of monitoring was not identified in the assessments and findings of any completed monitors since the previous assessment were not contained in the OT/PT assessments in an effort to determine efficacy of the interventions previously recommended and implemented.<br><br>Monitoring of wheelchairs, assistive devices for ambulation, and other equipment provided by OT/PT was included in the routine monitoring of the PNMPs as described above in Section O. There were no routine maintenance checks documented to assess the working condition of the wheelchairs, gait trainers, and adapted chairs, other than the PNMP monitoring.<br><br>A formal system did not exist that ensures staff responsible for positioning and transferring high-risk individuals receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff (please refer to Provision O.5).<br><br>A policy/protocol addressing the monitoring process did not exist that provided information regarding frequency of monitors and staff responsible. Based on review of the RGSC PNMP policy 500 01 rev 4/2011, a system was not in place to monitor staff implementation of PNMPs and other OT/PT interventions which included:<br>• Definition of monitoring process<br>• Identifies monitors (licensed professional for OT/PT intervention plans) and their roles and responsibilities<br>• Formal schedule for monitoring to occur<br>• Re-evaluation of monitors on an annual basis by therapists and/or assistants<br>• Results of monitoring activities in which deficiencies noted are formally shared for appropriate follow-up by the relevant supervisor<br><br>Although the data system collected data, it was not aggregated in a way that allowed productive trending and analysis. See Provision O.7 for more information.<br><br>On a regular basis, DSPs were not monitored for their continued competence in implementing the OT/PT programs outside of the PNMP monitors. Refresher trainings were not consistently provided to staff in | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | an effort to ensure staff remained knowledgeable of changing standards of practice. | |

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

1. OT and PT should ensure adequate participation by attending all ISP annual meetings so that information from reports may be clarified and presented to the full team. (Provision P.1)
2. Assessments, though improved, should clearly identify current status, impact of diagnoses on level of functioning, analysis of status compared to previous assessments, monitoring schedule, and community placement factors. (Provision P.1)
3. 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 OT, SLPs and/or psychology. (Provision P.2)
4. 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. (Provision P.3 and P.4)
5. A system must be developed that ensures all staff are trained on individual techniques prior to working with individuals with increased risks. (Provision P.3)

| SECTION Q: Dental Services | |
|---|---|
| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. RGSC Self-Assessment 8/13/12<br>2. RGSC Action Plan 8/9/12<br>3. RGSC Policy: Health Services Dental Services, dated 12/9/11 (no policy number)<br>4. Dental rehearsal check list for the most recent ten individuals who participated in a dental rehearsal<br>5. Complete dental records, and progress notes related to dental services for the past 6 months, along with the most recent ISP, and addendum to the ISP for dental services for Individuals #140, #11, #86, #47, #23, and #40<br>6. List of all dental emergencies, and associated dental records and related integrated progress notes, for the past six months<br>7. Copy of dental schedule for past six months<br>**People Interviewed:**<br>1. Yolanda Gonzalez, CNE<br>2. Mario Menchasca, RDH<br>**Meeting Attended/Observations:**<br>1. None |
| | **Facility Self-Assessment:**<br>The Facility reported that it was not in compliance with Provisions Q1 and Q2, of the Settlement Agreement. The Monitoring Team concurs with this self-assessment of noncompliance; however, the Monitoring Team does not concur with the Facility's methodology of assessing compliance. For example, for Provision Q1, the Facility reviewed a sample of appointments completed by the nursing department to ensure they are followed through to resolution and re-scheduled as appropriate but did not review whether emergency dental care was timely and was unable to provide to the Monitoring Team documentation that could verify it had a system to track dental services. For Provision Q2, the self-assessment reported that 94% of individuals have completed dental rehearsals; however, policy did not require, and documentation showed the Facility did not provide, frequent enough rehearsals to be effective. Furthermore, to assess compliance the Facility should be assessing adequacy, and completion of its action plan.<br><br>The Monitoring Team agrees with the intent of the Facility's action plan; however, the Monitoring Team noted that the Facility should be more specific, with regards to each action listed. For example, the Facility listed that it will ensure that all individuals are assessed for suction toothbrushing, but does not list what will be necessary to achieve this action. Importantly, the Facility requires a policy, and procedure on how, who, and when will individuals be screened for suction toothbrushing, In addition, the Facility should incorporate recommendations delineated in this report. |
| | **Summary of Monitor's Assessment:**<br>The Monitoring Team noted that the Facility had made some progress with regards to dental services, |

| | |
|---|---|
| | primarily in the area of oral hygiene, and by enhancing resources to support administrative functions for dental services. The Monitoring Team was pleased to learn that in the near future, the contract hygienist will assume the responsibility of overseeing dental services. Because of fragmented oversight, the Facility made little other progress towards compliance. Specific concerns regarding Provision Q1, and Provision Q2 are as follows:<br><br>**Provision Q1:** Dental services at the Facility remain fragmented, and without formal operational procedures, and practices. The Facility did not have a mechanism to efficaciously and efficiently track dental services, and was unable to provide meaningful clinical information and data related to oral health care at the Facility, and for these reasons the Monitoring Team determined that the Facility remains not in compliance with Provision Q1. Compliance will require formalizing functional processes that will ensure an understanding of each individual's oral health care needs, and to ensure that all oral health care issues are addressed timely.<br><br>**Provision Q2:** At the time of this review, the Facility did not have a formal dental office, or appropriate staff assigned to oversee the delivery and outcomes of dental services; did not have a process to provide QA for dental services; provided only minimal attempts at programs to minimize use of dental sedation, such as dental desensitization; and did not closely monitor the use of pre-treatment sedation, and anesthesia. For these reasons the Monitoring Team determined that the Facility was not in compliance with Provision Q2. The Facility must develop a formal mechanism, with appropriate staff to oversee dental services and ensure the aforementioned. |

| # | 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 compliance with Provision Q1, the Monitoring Team met with Yolanda Gonzalez, CNE, whom at the time of this review was responsible for dental services at the Facility, assessed dental administrative processes, reviewed dental records, individual support plans (ISPs), and dental progress notes.<br><br><u>Dental Administration</u><br>At the time of this review, the Facility did not maintain a formal dental department. Yolanda Gonzalez, CNE was assigned responsibility for dental services, but because of many other obligations, was unable to devote the necessary time and resources to develop a dental department. The Facility had increased the contract hours of the Facility's contract hygienist from ten to 20 hours per week, and the Monitoring Team was informed that the hygienist will assume responsibility of leading dental activities for the Facility in the near future.<br><br>All Dental treatments were delivered off campus, at community based dental offices. In addition to monitoring of oral care, such as tooth brushing, and suction toothbrushing, the contract hygienist provides direct care to individuals at a community based dental | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | office.<br><br>Dental Emergency<br>The Facility maintained a policy that delineated emergency dental service, that is delineated in RGSC Policy: Health Services Dental Services, dated 12/9/11 (no policy number). In the event of a dental emergency the unit nurse will notify the physician on call to triage the issue. The individual will then either be sent to the local hospital for emergency dental treatment, or scheduled for an appointment with a community-based dentist. The Facility did not maintain a mechanism to effectively track dental emergencies. Two dental emergencies reported to the Monitoring Team; the Monitoring Team reviewed the dental records, physician and nurses progress notes for Individuals #2 and #97. The Monitoring Team determined that both individuals received appropriate and timely medical and dental treatment for their dental emergency. The Facility must develop a mechanism to track all dental emergencies through resolution of treatment.<br><br>Routine Dental Care<br>The Facility did not maintain a mechanism to track dental services, and was unable to demonstrate which individuals were actually current with regards to their oral health care needs. It was not possible for the Facility to demonstrate which individuals were current with their dental services, what services had been provided, or what services were pending. The Facility is awaiting implementation of a new dental database system that should address such issues.<br><br>Dental Scheduling<br>Yolanda Gonzalez reported to the Monitoring Team that the dental schedule was not current because of staffing deficiencies. Regardless, the scheduling system did not enable a meaningful review of scheduled or pending dental service. The Facility was awaiting implementation of a new dental database system that should address this issue.<br><br>Suction Toothbrushing<br>The Facility did not have a process to assess individuals for the need of suction toothbrushing, for indications other then having a G-tube. All three individuals who had G-tubes at the Facility were provided suction toothbrushing by nursing staff.<br><br>Oral Hygiene<br>The Facility contracts with a contract dental hygienist, who provides 20 hours of service to the Facility. At the time of this review the hygienist reported that he provided training and supervision of direct care staff, who assist individual with their oral hygiene needs; there was no policy or procedure for this process, and record keeping of training sessions, and evaluations was not consistently maintained. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Dental X-Rays<br>The Facility did not have a method in place to track dental x-rays, and was unaware of the status of dental x-rays for individuals.<br><br>Summary<br>Dental services at the Facility remained fragmented, and without formal operational procedures, and practices. The Facility did not have a mechanism to efficaciously and efficiently track dental services, and was unable to provide meaningful clinical information and data related to oral health care at the Facility, and for these reasons the Monitoring Team determined that the Facility remains not in compliance with Provision Q1. Compliance will require formalizing functional processes that will ensure an understanding of each individual's oral health care needs, and to ensure that all oral health care issues are addressed timely. | |
| 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. | To assess compliance with Provision Q2, the Monitoring Team reviewed dental records, physician and nurses progress notes, personal support plans and the Facility's policy for dental desensitization. In addition, the Monitoring Team discussed dental services with Yolanda Gonzalez CNE. Issues addressed for Provision Q2 included pre-treatment oral sedations, anesthesia, integration of dental services into the IPN and ISP, methods used to minimize the use of sedation and restrictive practices, and the Facility's QA process for dental services.<br><br>Pre-Treatment Oral Sedation<br>Because the Facility did not maintain an effective mechanism to track dental treatments and related issues, the Facility was unable to closely monitor the use of pre-treatment oral sedation, and could not provide data and analysis regarding the use of pre-treatment oral sedation for dental procedures.<br><br>Intravenous Sedation<br>The Facility reported that no individuals at the Facility were provided intravenous sedation for dental procedures. Individuals are provided oral sedation, general sedation, or no sedation.<br><br>General Anesthesia<br>The Facility reported that a number of individuals require general anesthesia; however, it had made no progress in developing a system to readily identify those individuals requiring general anesthesia, or who have received general anesthesia. The only method available to determine if someone received general anesthesia is by either reviewing all of the clinical records, or by reviewing the dental schedule, for those individuals who had | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | seen a specific dentist that provides treatments with general anesthesia.<br><br>Integration Of Dental Services Into The IPN And ISP<br>The Facility did not maintain a specific dental record for individuals at the Facility. The Community dentist maintains original dental progress notes, assessments, and diagnostic results, and does complete a dental consultation report, and provided a copy of the dental progress/treatment record for individuals seen at their dental office. The Monitoring Team reviewed all dental consultations reports and dental progress notes completed by the community dentist in March, and in July, 2012. The Monitoring Team noted that in each case the dental consultation report was completed appropriately, and provided a description of dental services, and the dental progress notes were completed. However, no documentation indicated review of these consultation reports by a Facility clinician or referral to the IDT for review.<br><br>By reviewing the dental schedule, the Facility identified a total of six individuals who were provided general anesthesia for their dental services. The Monitoring Team reviewed the ISPs for each of these cases. The ISPs of three out of the six examples (50%) did not discuss dental health care; and zero out of six (0%) provided a comprehensive overview of the individual's oral health care condition, prognosis, and required supports. Importantly, the Monitoring Team was informed by Yolanda Gonzalez that non-dental professionals develop all information that is reported to the IDT, and delineated in the ISP. The Facility must ensure that a dental professional is available to participate at IDT, community living discharge planning (CLDP), and ISP meetings to help ensure that IDT members are well informed of all dental health care issues, including past and pending treatments, current oral health condition, risk and benefits of treatments, including sedation and anesthesia, and to review desensitization attempts.<br><br>Interventions To Minimize The Use Of Sedating Medications And/Or Restraints<br>The Facility continued with its dental rehearsal program. The Monitoring Team reviewed documentation of the ten most recent individuals who had participated with a dental rehearsal. For that past six month period, zero out of ten (0%) were seen on a regular basis for dental rehearsals; three of the ten (30%) had only received one dental rehearsal; two out of ten (20%) had only received two dental rehearsals; three out of ten (30%) received three dental rehearsals; and two out of ten (20%) received five dental rehearsals. This number of sessions would be unlikely to provide enough opportunities for desensitization or learning to produce significant change in response to dental services and reduce use of pre-treatment sedation.<br><br>Review of the Facility's policy for dental desensitization, RGSC-Health Services Dental | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Desensitization, dated 12/9/11 was not followed by the Facility, and did not reflect the dental rehearsal program initiated by the Facility.<br><br>Dental Quality Assurance (QA)<br>Yolanda Gonzalez reported to the Monitoring Team that the Facility has not developed a QA process for dental services. It is essential that the Facility develop a process to assess outcomes of dental services and programs to minimize use of sedating medications and restraints. For example, the Facility should closely monitor individuals for adverse events following dental services, pre-treatment sedation, and anesthesia.<br><br>Scheduling And Missed Appointments<br>The Facility did not maintain a process that would efficiently and efficaciously enable scheduling of dental appointments, while allowing for tracking and trending all past dental treatments, pending treatments, types of treatments, or missed appointments. Yolanda Gonzalez informed the Monitoring Team that the Facility is awaiting implementation of a dental database system that is being provided by DADS central office, that will enhance the Facility's ability to better track, and trend dental services.<br><br>Summary<br>At the time of this review, the Facility did not have a formal dental office, or appropriate staff assigned to oversee the delivery, and outcomes of dental services; did not have a process to provide QA for dental services; provided only minimal attempts at programs to minimize use of sedating medications and restraints, such as desensitization; and did not closely monitor the use of pre-treatment sedation, and anesthesia. For these reasons the Monitoring Team determined that the Facility was not in compliance with Provision Q2. The Facility must develop an office, with appropriate staff to oversee dental services, and ensure the aforementioned. | |

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

1. Develop and implement a mechanism to track all dental emergencies through treatment resolution (Provision Q1)
2. Implement a database mechanism that will accurate identify status of all completed, scheduled and pending dental treatments (Provisions Q1 and Q2)
3. The Facility must develop and implement a process to assess individuals for suction toothbrushing. All individuals at risk for aspiration and aspiration pneumonia should be periodically assessed for suction toothbrushing. (Provision Q1)
4. Develop, and implement a policy and procedure for the training, and supervision for oral hygiene, and ensure that training records are kept, and monitoring of oral hygiene outcomes is documented (Provision Q1)
5. Develop and implement a policy that tracks dental x-rays, and ensure that individuals benefit by dental imaging, as recommended by the ADA, and more frequently when clinically indicated. (Provision Q1)
6. The Facility must enhance its dental rehearsal process and ensure that individuals benefit from more frequent and consistent opportunities for

rehearsals to assist in reducing the need for restrictive procedures when receiving dental services.

7. The Facility must develop a policy and procedure for interventions used to help minimize the use of sedating medications and/or restraint for dental and medical procedures (Provision Q2)
8. Enhance reporting of dental services in the ISP, IDT, and CLDP meetings by ensuring that a dental professional is available to provide the Facility with information about the individual's current oral health condition, necessary supports and services required to support the individual, overview of past and pending oral health treatments, prognosis of oral health condition, risks and benefits of dental treatments, and the use of pre-treatment sedation and anesthesia. (Provision Q2)
9. Develop and implement a QA process that tracks and trends outcomes of dental services, especially adverse outcomes following oral health care procedures, pre-treatment sedation, and anesthesia. (Provision Q2)
10. When operational, implement the DADS dental database system. (Provision Q2 and Q1)
11. Develop and implement a process that enables robust tracking, trending, and monitoring the use of all pre-treatment oral sedation, i.v sedation, and general anesthesia, when used for dental services (Provisions Q1 and 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:**<br>**Documents Reviewed:**<br>1. RGSC Self Assessment (8/13/12)<br>2. RGSC Action Plan (8/9/12)<br>3. RGSC Communication Services Standard Operating Procedure MR700 07 (1/2010)<br>4. Monitoring tools template for Augmentative and Assistive Communication (AAC) and Speech Language Pathology (SLP) programs<br>5. List of individuals receiving direct speech services, and focus of intervention<br>6. Record reviews:<br>f. Sample #1: Individuals #26, #29, #35, #47, #60, and #79<br>g. Sample #2: Individuals #48, #51, #72, #97 and #126<br>h. Sample #3: Individuals #3, #33, #46, and #81<br>i. Sample #4: Individuals #24, #81, and #132<br>j. Sample #5: Individuals #36, #55, #84 and #88<br>k. Sample #6: Individuals #51, #76, and #134<br>7. PBSPs and Communication Assessments for Sample #5<br>8. Communication Assessments for all samples identified above<br>9. Communication programs for Sample #5 and #6<br>10. ISPs for samples above<br>11. List of Individuals with communication devices (Individuals #29, #51, #74, #75, #84, #88, #93, #94, #97, #118, and #149)<br>12. Speech and Hearing Equipment Form<br>13. List of Individuals with Communication related Skill Acquisition Programs (SAPS)<br>**People Interviewed:**<br>1. Jane Augustine PT<br>2. Belinda Lopez SLP<br>3. Sotera Villalpando SLP<br>4. Four direct support professionals (2 La Paloma, 1 El Paisano, 1 Vocational education)<br>**Meeting Attended/Observations:**<br>1. PNMT meeting 8/28/2012<br>2. ISP annual planning meeting for Individual #61<br>3. Vocational Education 8/28/2012<br>4. La Paloma lunch and dinner<br>5. El Paisano lunch and dinner<br>6. Las Paloma and El Paisano transition times |
| | **Facility Self-Assessment:**<br>RGSC's Self-Assessment, updated 8/13/2012 and Action Plan 8/9/12, provided comments/status for Sections 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. |

| | |
|---|---|
| | For the self-assessment, the Facility described, for each provision item, the activities the Facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale.<br><br>Overall, the Self Assessment and Action Plans included appropriate steps that would assist in the state in gaining compliance; however, the activities at times were not consistently in line with what the Monitoring Team assesses as indicated in this report. Examples of this occurring included:<br>▪ Not all requirements of the Settlement Agreement had been reviewed. More specifically, within a sub-section, the Settlement Agreement might have numerous requirements, but only some were included in the Facility's Self-Assessment (e.g., Provision R.1 did not fully address all the expected roles and responsibilities of the SLP).<br>▪ Lack of clarity with regards to chosen samples. |
| | **Summary of Monitor's Assessment:**<br>There were many positives noted within this section. The number of shared devices continued to increase 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.<br><br>Communication assessments have become more comprehensive and were noted to do a better job at clearly identifying the individual's communicative strengths and weakness. More collaboration remained needed with behavior supports so that there was a cohesive approach to addressing problematic behaviors that had communication as a primary component.<br><br>**Provision R.1:** This provision was determined to be not in compliance. RGSC did not have a comprehensive communication procedure/policy that addressed all components of a functioning system. Additionally, this provision of the Settlement Agreement includes a number of requirements that are addressed in subsequent sections within Section R and which have the ability to affect the Facility's compliance with the Settlement Agreement.<br><br>**Provision R.2:** This provision was determined to be not in compliance. The communication assessments did not consistently include the following elements:<br>• Recommendations for direct interventions and/or skill acquisition programs including the use of AAC as indicated for individuals with identified communication deficits<br>• Manner in which strategies, interventions, and programs should be utilized throughout the day<br>• Measurable objectives<br><br>**Provision R.3:** This provision was determined to be not in compliance. AAC devices were not consistently available to the individuals and not consistently utilized by individuals. Additionally, DSPs interviewed were not knowledgeable of the communication programs.<br><br>**Provision R.4:** This provision was determined to be not in compliance. There was limited monitoring of |

| | |
|---|---|
| | communication devices or integration of communication programs and strategies into the IDT. |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| R1 | Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs. | 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.<br><br>Sample #2 consisted of five individuals who were chosen from a list provided by RGSC of individuals who were identified as being at an increased risk of aspiration.<br><br>Sample# 3 consisted of four individuals identified by the Facility with severe expressive or receptive language disorders with assessments completed in the last 12 months.<br><br>Sample #4 consisted of three individuals admitted since the last compliance review.<br><br>Sample #5 consisted of four individuals with a PBSP and communication deficits.<br><br>Sample #6 consisted of three individuals receiving direct speech services.<br><br>This provision of the Settlement Agreement includes a number of requirements that are addressed in subsequent sections within Section R and which have the ability to affect the Facility's compliance with the Settlement Agreement. This provision will address compliance with current staffing, staff qualifications, adequate number of speech language pathologists, and continuing education. The SLP assessment process and the development and implementation of programs are discussed in Provision R.2. Staff training will be addressed in Provision R.3 and the Facility's monitoring system will be presented in Provision R.4. Compliance in Provision R1 related to the adequacy of clinicians must be determined by compliance in Provisions R2 through R4.<br><br><u>Staffing:</u><br>At the time of the review, RGSC had two full time Speech Language Pathologists. The Speech Language Pathologists consisted of Belinda Lopez SLP and Sotera Villalpando SLP. Each Therapist carried a full caseload in addition to other duties such as PNMT.<br><br>There were no open SLP positions at the time of this review.<br><br><u>Qualifications:</u><br>The Facility did document appropriate qualifications for licensed SLPs.<br>• Two of two staff (100%) were licensed to practice in the state of Texas.<br>• Two of two staff (100%) had evidence of ASHA certification. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Continuing Education:<br>Documentation of continuing education courses completed by the SLPs was submitted. The continuing education attended by the clinicians included the following topics:<br>• Texas Assistive Technology Network Conference (6/12/2012 to 6/14/2012)<br>• Development and Implementation of on Skilled Acquisition Programs<br>• Evidence Based Practices for AAC Evaluations<br><br>Based on a review of continuing education: Two of two SLP staff (100%) had completed continuing education related to communication in an area that was relevant to communication and transferrable to the population served.<br><br>SLP Participation<br>The Facility did not provide adequate participation of speech language pathologists or other professionals (i.e. AT specialists) with specialized training or experience. Evidence was as follows:<br>• Individuals did not receive direct services as indicated by need or request by the IDT (see Provision R.3)<br>• Devices were not utilized and systems or devices were not monitored at a frequency that ensured appropriateness and continued use of the device (See Provision R.3)<br><br>Facility Policy:<br>RGSC provided an operating procedure developed January 2012, that provided operating procedures for the delivery of communication supports and services. The following components should be but were not included in this procedure:<br>• Outlining of assessment schedule.<br>• Frequency of assessments/updates.<br>• Timelines for completion of comprehensive assessments<br>• Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication<br>• Addressing a process for effectiveness monitoring by the SLP<br>• Criteria for providing an update<br>• Methods of tracking progress and documentation standards related to intervention plans<br>• Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution<br><br>Included in the operating procedures were general statements regarding communication | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | services. For example, The operating procedure stated that assessments would be provided according to the Master Schedule. While a Master Schedule existed, it was not clear beyond the date specified on the schedule what the standard frequency of assessments would be for individuals who received speech supports versus those who did not receive services. | |
| 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. | <u>Assessment Plan:</u><br>As mentioned in Provision R.1, RGSC had a master plan that ensured every individual received a comprehensive speech-language assessment with AAC screening and/or evaluation. It appeared that all individuals received assessments annually but as stated previously, this process was not integrated into the operating procedures.<br><br>Since the previous compliance visit, 38 comprehensive communication assessments had been completed.<br><br>Per review of new admissions (Sample #4):<br>• Three of three individuals (100%) received a communication screening or assessment within 30 days of admission or readmission.<br>• Three of three individuals identified with therapy needs through a screening (100%) received a comprehensive communication assessment within 30 days of identification.<br><br><u>Communication Assessment:</u><br>Per generally accepted clinical standards, a comprehensive assessment should contain the following elements, at a minimum:<br>• Signed and dated by the clinician upon completion of the written report<br>• Dated as completed 10 days prior to the annual ISP<br>• Diagnoses and relevance of impact on communication<br>• Individual preferences, strengths, interests, likes, and dislikes<br>• Documentation of how the individual's communication abilities impact their risk levels<br>• Description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day.<br>• Evidence of observations by SLPs in the individual's natural environments (day program, home, work)<br>• Evidence of discussion of the use of a Communication Dictionary as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who were non-verbal<br>• Discussion of the expansion of the individual's current abilities<br>• Discussion of the individual's potential to develop new communication skills | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • Effectiveness of current supports, including monitoring findings<br>• Comparative analysis of health and functional status from the previous year<br>• Comparative analysis of current communication function with previous assessments<br>• Identify need for direct or indirect speech language services<br>• Reassessment schedule<br>• Monitoring schedule<br>• Recommendations for direct interventions and/or skill acquisition programs including the use of AAC as indicated for individuals with identified communication deficits<br>• Factors for community placement and a determination of the most appropriate living environment<br>• Recommendations for services and supports in the community<br>• Manner in which strategies, interventions, and programs should be utilized throughout the day.<br><br>Based on review of 18 assessments (Samples #1, #2, #3, and #4), 12 of 18 (67%) individuals had comprehensive assessments that contained each of these elements.<br><br>Those assessments that were not considered to be comprehensive did not include the following elements:<br>• Recommendations for direct interventions and/or skill acquisition programs including the use of AAC as indicated for individuals with identified communication deficits<br>• Manner in which strategies, interventions, and programs should be utilized throughout the day<br>• Measurable Objectives<br><br>Although recommendations were provided, they were often generic and were not specific to the individual. An example of this was the recommendation to utilize the home communication board and to provide choices without offering specifics regarding how staff should utilize the boards and activities in which it would be appropriate.<br><br>Through interview with the Speech Therapists and based on review of individuals observed to be nonverbal and/or with a limited form of expressive language, it was noted that there were numerous individuals in need of AAC who were not consistently provided with base communication goals to improve expressive language.<br><br><u>SLP and Psychology Collaboration:</u><br>Based on review of four records for individuals in Sample #5 the following was noted for | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | these four individuals:<br>• Zero of four (0%) communication assessments and PBSPs reviewed addressed the connection between the PBSP and the recommendations contained in the communication assessment.<br>• Four of four communication assessments reviewed (100%) contained evidence of review of the PBSP by the SLP.<br><br>Additionally, there were often unclear connections established between the issues identified in the PBSP and the correlating objective established by the SLP to assist with the identified purpose of the PBSP. An example included Individual #55 who had episodes of aggression and/or refusal when prompted that it was time to eat and bathe. The SLP identified these issues in the Communication Assessment but also recommended adding pictures to the communication notebook. The Skill Acquisition Program (SAP) for completing tasks, which was related to the PBSP, focused on adding pictures to a communication wallet that was identified through documentation as a means the individual did not functionally utilize or currently have the skills to utilize. It would be better to train use of the wallet, but to include in the SAP methods more likely to be effective in training the desired skills.<br><br>The SLP at the time of the review was participating as a member of the Behavior Services Peer Review but the Monitoring Team was unsure if this was the proper meeting for SLP involvement as the purpose of the meeting was to focus more on peer review of existing plans and not necessarily on the development of new PBSPs. A more effective way to address the concerns would be to have SLP and Psychology have increased collaboration prior to the ISP so the SAPs by the SLP would complement the PBSP and vice versa. | |
| 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. | <u>Integration of Communication in the ISP:</u><br>Based on review of the ISPs for 18 individuals in Samples #1, #2, #3, and #4 the following was noted:<br>• In 17 of 22 ISPs reviewed (77%) for individuals with communication needs, an SLP attended the annual meeting.<br>• In 16 of 22 ISPs reviewed (72%), the type of AAC and/or communication supports was identified.<br>• Communication Dictionaries/Strategies provided to four of 22 individuals (18%) were reviewed at least annually by the IDT as evidenced in the ISP.<br>• In 17 of 22 ISPs reviewed (7%) a description of how the individual communicated, including the AAC system if they had one, was included.<br>• Zero of 22 ISPs reviewed (0%) included how communication interventions were to be integrated into the individual's daily routine.<br>• Zero of 22 ISPs reviewed (0%) included information regarding the individual's | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP.<br><br><u>Individual-Specific AAC Systems:</u><br>There are 20 individuals living at RGSCC who were identified as having severe language deficits. Per review of the AAC list provided by RGSC, 12 individuals had personal AAC devices. Many individuals had recommendations to utilize the common area devices but recommendations were vague and did not provide clear direction as to how and when individuals would utilize such devices.<br><br>Additionally, many individuals who had AAC did not have associated SAPs to train in the use of the devices even if they were not independent in its use. Examples included Individuals #88 and #94.<br><br>Personal AAC devices ranged from communication wallets and books to go talk devices.<br><br>Observations were conducted in three areas (La Paloma, El Paisano, and Vocational Education) for 11 individuals with AAC systems identified on the list provided by RGSC. Findings included the following:<br>• AAC systems for four of 11 individuals (36%) were present.<br>• AAC systems for three of 11 individuals (27%) were noted to be in use.<br>• AAC systems for 11 of 11 individuals (100%) were portable but not consistently present or utilized as stated above.<br>• AAC systems for 11 of 11 individuals (100%) were functional but again not utilized.<br><br><u>General Use AAC Devices:</u><br>RGSC had 34 shared communication devices. Devices consisted of wall boards, and various voice buttons and switches (i.e., Put em arounds, Cheap Talks, and Twin Talks) Devices were located in common areas, near bathrooms, and the entrance/exits.<br><br>Observations were completed in La Paloma, El Paisano, and Vocational Education to determine the presence and use of general AAC devices. Findings included the following:<br>• Three of the three areas (100%) had general use AAC devices present in the common areas.<br>• Thirty four of the 34 general use AAC devices (100%) noted contained clear directives on how staff should use these devices.<br>• Thirty four of 34 general use AAC devices (100%) noted had a clear function within that setting/situation.<br>• Zero of 34 general use AAC devices observed (0%) were used by individuals | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | during situations in which use of devices were appropriate (i.e., mealtime, bathing, going outside).<br><br><u>Direct Communication Interventions:</u><br>Overall, only three individuals were receiving direct services by the SLPs at the time of the review. Out of the three services, only one focused on communication.<br><br>Direct communication-related intervention plans for individuals included in Sample #6 were reviewed.<br><br>Generally accepted practice standards for comprehensive progress notes related to communication interventions include:<br>• Contained information regarding whether the individual showed progress with the stated goal.<br>• Described the benefit of device and/or goal to the individual.<br>• Reported the consistency of implementation.<br>• Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress.<br><br>Documentation of SLP review for zero of three individuals (0%) was comprehensive as per the indicators outlined above. At times, the notes contained the needed information, but consistency of documentation was an issue. The progress reviewed that were not comprehensive were missing the following:<br>• Contained information regarding whether the individual showed progress with the stated goal.<br>• Described the benefit of device and/or goal to the individual.<br>• Reported the consistency of implementation.<br>• Identified recommendations/revisions to the intervention plan as indicated related to the individual's progress or lack of progress.<br><br><u>Indirect Communication Supports:</u><br>Programs for individuals who received indirect communication supports included in Sample #3 were reviewed. The SAPs developed for these individuals were not noted in the record and "Me" books and as of this review had not been implemented although the programs had been written for an extended period of time. An example was Individual #46 whose plan was written 5/8/2012 but had not been implemented as of August 30, 2012.<br>• Quarterly documentation for zero of three individuals (0%) contained information regarding whether the individual showed progress with the stated goal(s). | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • Quarterly documentation for zero of three individuals (0%) identified the benefit of device and/or goal(s).<br>• Quarterly documentation for zero of three individuals (0%) identified consistency of implementation.<br>• Quarterly documentation for zero of three individuals (0%) identified recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress.<br><br>Per data provided by RGSC, only 19 individuals had communication SAPs but as mentioned previously, many individuals did not have their SAPs implemented and staff trained. Per review, 10/19 SAPs had been implemented. Most SAPs had been implemented in the past 3 months.<br><br><u>Staff Interviews:</u><br>Findings from the six staff interviews conducted on El Paisano, La Paloma, and Vocational Education included the following:<br>• In three of four interviews conducted (75%), direct support professionals stated whether the individual had an AAC system.<br>• In one of four interviews conducted (25%), direct support professionals located the individual's communication equipment.<br>• In two of four interviews conducted (50%), direct support professionals stated whether there was a communication program.<br>• In one of four interviews conducted (25%), direct support professionals described the communication program goal.<br>• In zero of four observations conducted (0%), direct support professionals implemented the communication program as written.<br>• In one of four interviews conducted (25%), direct support professionals showed where, when, and how data was recorded for the program.<br>• In one of four interviews conducted (25%), direct support professionals described the schedule for implementation of the communication program.<br>• In four of six interviews conducted (66%), direct support professionals identified how communication skills in the program were addressed throughout the day.<br>• In one of six interviews conducted (16%), direct support professionals stated that they had received individual-specific training for the program and/or AAC.<br>• In zero of four interviews conducted (0%), direct support professionals described individual-specific communication strategies as identified in the individual's PNMP, ISP, PBSP, and/or Communication Dictionary.<br><br><u>Competency-Based Training and Performance Check-offs:</u> | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Staff were provided with communication training as part of new employee orientation. All staff were required to participate in the class through group exercises and situational question answering. There was an annual refresher provided related to communication but per SLP, it had not been consistently implemented.<br><br>While the interactions of staff with the individuals were generally positive, much of the interaction observed by the Monitoring Team was specific to a task, with little other interactions that were meaningful, such as during a meal. Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities (using assistive technology), should be made a priority. This will only be possible when the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts.<br><br>Based on review of the NEO training curriculum and observations, direct support professionals, PNMPCs and therapy aides were provided with basic NEO competency-based training related to communication but RGSC did not provide information on competency based training related to individual devices or the use of shared devices.<br><br>New Employee Orientation included:<br>• Methods to enhance communication<br>• Implementation of programs<br>• Benefits and use of AAC<br>• Identification of non-verbal means of communication.<br><br>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.<br><br>As mentioned above, while the NEO training appeared to meet basic standards, missing from the process was the ability of Speech Staff to have the needed presence at the homes to model and guide staff through real life activities and situations. | |
| 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 | <u>Monitoring System:</u><br>RGSC developed 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. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually. | RGSC did not have a communication policy that included the following key elements:<br>• The frequency of monitoring.<br>• The process for identification, training, and validation for monitors.<br>• A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic).<br><br>Working condition and presence was informally monitored but the data acquired from this monitoring was not accumulated for trends analysis.<br><br>Refer to Provision R.3 for information regarding effectiveness monitoring. | |

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

1. While integration has improved between Psychology and the Speech Department, there remains a need to improve collaboration and consistency between the PBSP and the Communication plan of treatment. (Provision R.2)
2. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the PSPs and in the PNMPs. (Provision R.3)
3. Expand NEO training to include more opportunities for staff participation and return demonstration. (Provision R.3)
4. Staff would benefit from increased hands on modeling of the use and integration of devices with normal daily contexts by the SLPs. (Provision R.3)
5. Staff must do a better job at implementing not only individual AAC devices but also the shared devices that are located throughout the center. (Provision R.3)
6. A database should be developed that assist the department in capturing the data from the completed monitors and allow for the analysis of such data by the SLPS in an effort to improve overall services. (Provision R.4)

| 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:**<br>**Documents Reviewed:**<br>1. RGSC Self-Assessment (8/13/12)<br>2. RGSC Action Plan (8/9/12)<br>3. RGSC August 2012 Presentation notes<br>4. Documents that were reviewed included the annual ISP, ISP updates, Specific Program Objectives/Skill Acquisition Plans (SPOs/SAPs), Positive Behavior Support Plans (PBSPs), Structural and Functional assessments (SFAs), treatment data, teaching data, progress notes, psychology and psychiatry evaluations, physician's notes, psychotropic drug reviews, consents and approvals for restrictive interventions, safety and risk assessments, task analyses, and behavioral and functional assessments. All documents were reviewed in the context of the POI and Supplemental POI and included the following individuals: Individual #61 and #141.<br>**People Interviewed:**<br>1. Janie Villa – QDDP Coordinator<br>2. Ruben Nieto, BCBA – Psychology Director<br>3. Vanessa Villarreal, M.Ed. – Interim Psychology Director<br>4. Samantha Salinas, MSW – Contract Associate Psychologist<br>5. Cheryl Fielding, PhD, BCBA – Contract Psychologist<br>6. Alonzo Andrews, M.A., BCBA – Contract Psychologist<br>7. Direct Support Professionals: Approximately 15 staff members in residences, classrooms and vocational settings<br>**Meeting Attended/Observations:**<br>1. ISP Meeting (8/28/2012)<br>2. Peer Review Committee (PBSC) (8/29/2012)<br>3. Human Rights Committee (HRC) (8/30/2012)<br>4. Quarterly Psychotropic Drug Review (8/27/2012)<br>5. Observations were conducted in all residences, classrooms, vocational settings, and leisure areas on 8/28, 8/29, and 8/30. |
| | **Facility Self-Assessment:**<br>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 review of the Facility Self-Assessment was difficult at times due to differences in the material and processes to be reviewed. The Monitor had been asked to focus the review upon new ISPs and SAPs because of new procedures in place for those areas. The Self-Assessment, however, was in most cases related to ISP, SAPs, and practices relevant to the procedures being replaced. Nevertheless, there were circumstances in which the Self-Assessment provided the Monitor with valuable insights. |

| | |
|---|---|
| | One concern in relation to the self-assessment was the emphasis upon quantitative rather than qualitative measures. In many circumstances, the self-assessment provided information on the number of tasks completed or the number of adequate assessments. The Self-Assessment failed, however, to provide evidence for a measure of how well the tasks were completed or how it was determined that the reports were adequate. Any attempt to assess status must ensure that quality is a focus of the measurement process.<br><br>A particularly striking example of this was the assessment of Provision S.3.a. This Provision involves effectively meeting the needs of the individual in ways that are functional and practical. The conclusion of the Self-Assessment stated that, "…this provision is not in substantial [compliance] because review by the QDDPs is occurring 60 days after the data is collected so the implementation of a new or revised objective is not timely." Timely review is an important aspect of ensuring that individual needs are met. Neither the provided statement, nor the evidence cited, however, reflected any relation to whether services truly met the needs of the individuals or whether the services and programs were functional and practical.<br><br>A related concern noted in the Self-Assessment was the paucity of data to support conclusions presented by the Facility. In Provision S.1, the Facility stated, "Training on Skill Acquisition Plans (SAPS) was provided on 07/25/2012 and plans are in place to implement the new format immediately. Current SAPs do not contain all the required elements but the new format does." Although the new format for the SAPs might include essential components of a skill acquisition program, there was no evidence in the Self-Assessment to support the conclusion presented.<br><br>The Action Plans submitted by RGSC shared many of the weaknesses identified in the Facility Self-Assessment. In many circumstances, the plans emphasized quantitative rather than qualitative measures. An example of this was Action Step 4 under Provision S.3. The Action Plan stated, "Ensure that the individuals living at the facility receive and benefit from skill acquisition training" with evidence for completion being described as, "Trend Skill acquisition Successes or Lack of Successes for all Individuals Progress Notes." This Action Plan was scheduled to begin on 9/1/2012 and be completed by 9/30/2012. Even if it was possible to implement the trending analysis within the stated timeframe, providing access to such a system would not ensure that individuals living at the Facility received and benefitted from skill acquisition training. The data from such a system could prove useful in determining benefits from skill acquisition programs, but alone would not alter either the content of or benefit from those programs.<br><br>Based upon the Self-Assessment and Action Plans provided by the Facility, it was not evident that either process was sufficient to guide the process of complying with the Settlement Agreement. |
| | **Summary of Monitor's Assessment:**<br>Observations, interviews, and record reviews were conducted on-site at RGSC from 8/27/2012 through 8/31/2012. Record reviews continued off-site for several days following the site visit. Based upon information obtained during the site visit, it was evident that RGSC had not achieved compliance with any Provision of Section S of the Settlement Agreement. |

| | |
|---|---|
| | The Facility had requested that the Monitoring Team's review focus upon ISPs and Skill Acquisition Programs (SAPs) that reflected procedures that had only recently been implemented. This limited the review to two ISPs and seven SAPs. Due to this small sample, any conclusions reached by the Monitor must be considered as provisional.<br><br>Despite the new procedures and formats implemented by RGSC, it was not indicated that the Facility had substantially improved upon existing practices. In many areas, there were no appreciable improvements in the quality of ISPs or SAPs. Where improvement was noted, the change was modest at best.<br><br>In regard to the ISPs reviewed, it was difficult to identify the process by which the IDT identified individual needs, determined priorities for intervention, and selected a formal intervention process or program. It was not evident that assessment data were thoroughly considered by the IDT. Furthermore, even when individual preferences were identified, the ISP reflected decisions counter to those preferences.<br><br>Similar to the circumstances with the ISPs, many of the reviewed SAPs reflected a continuation of weaknesses noted during previous site visits. Although some form of task analysis was reflected in several programs, there was no evidence to suggest that the task analyses reflected individualized assessment. Instructions for staff tasked with implementing the SAPs were frequently lacking in specifics.<br><br>The Monitoring Team appreciated that the Facility was making efforts to improve services and achieve compliance with the Settlement Agreement. Based upon the materials available for review, however, it was not evident that the steps taken by the Facility had brought about substantial compliance with the Settlement Agreement. |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| S1 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, | <u>Historical Perspective</u><br>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 unequivocally that the 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 site visit in March 2012, only marginal improvement was noted, with two of 31 ISPs (6%) being based upon assessments and only one of 31 (3%) having reflected individualization.<br><br><u>Current Site Visit</u><br>During the current site visit, the Monitor was asked to focus upon only those ISPs and Skill Acquisition Programs (SAPs) that had been developed using a recently developed approach. This substantially limited the scope of the review, as only two ISPs had been completed by the end of the site visit; those ISPs were for Individuals #61 and #141. Based | Noncompliance |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>and freedom from undue use of restraint.</td><td>upon those two ISPs, seven SAPs had been developed; five were provided for Individual #61 and two for Individual #141. As a result, any statement offered in Section S of this report must be considered provisional.<br><br><u>Use of Assessment Information in Planning Skill Acquisition</u><br>Adequate assessment is essential for understanding an individual's abilities, identifying specific needs, and determining the strengths upon which new skills can be based. Without thorough and comprehensive assessments, skill acquisition training is unlikely to be successful or meaningful to the individual who is to participate in the training.<br><br>Based upon the documentation provided by RGSC, there was little indication that the Facility had provided adequate assessment in relation to skill acquisition training.<br><br>
<table>
<tr><td></td><td>02/2010</td><td>02/2012</td><td>8/2012</td></tr>
<tr><td>Skill acquisition plans are implemented to address needs identified in:</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>ISP</td><td>0%</td><td>6%</td><td>0%</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>0%</td></tr>
<tr><td>Skill acquisition plans are related to the individual's preferences.</td><td>0%</td><td>3%</td><td>0%</td></tr>
</table>
<br>Observation of the ISP annual planning meeting for Individuals #61 and #141 provided some limited evidence that information from assessments was used to develop an ISP that outlines protections, services, and supports. For example:<br>• For Individual #61, when the IDT discussed the PBSP and the psychiatric evaluation, data were provided.<br>• For Individual #141, the speech pathologist stated the individual has a training objective to identify a dollar; this was selected based on the Speech-Language/Communication Assessment. However, this was raised during a discussion of whether to restrict the individual's right to keep money; the ISP did not state this to be a goal. Furthermore, it is questionable how this would serve as an appropriate communication goal. The assessment identified the individual's communication skills but did not indicate how those could be expanded other than by identifying a dollar. The Speech Pathologist also recommended the PNMP be changed to state that staff should see the Communication Strategies, not the Communication Dictionary, to interact with the individual. The assessment did not identify or specify strategies that would likely be effective for communication.</td><td></td></tr>
</table>

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | There were also improvements noted in some of the assessment processes at RGSC. Examples included:<br>• As reported in Provision J6, psychiatric assessments followed the requirements of Appendix B and were based on current, accurate, and complete clinical and behavioral data.<br>• As reported in Provision L1, physical examinations conducted for the annual medical assessment were more comprehensive than in the past.<br>• As reported in Provision P1, the OT and PT completed annual assessments/updates collaboratively.<br><br>In reviewing the ISPs for Individuals #61 and #141, however, it was difficult to determine when or if the IDT had identified specific needs. Neither of the reviewed ISPs included information regarding preferences or strengths that was of sufficient validity to be meaningful. In many areas, the narrative of the ISP did not reflect a coherent discussion of the topics discussed by the IDT. Subjective opinion and anecdotal reports often were presented with greater emphasis or in the place of formal assessment data. It was also common to find that multiple issues were presented within a single paragraph, with a formal conclusion being reached on few if any of these topics. An example of these issues is presented below.<br>• For individual #141, the ISP contained an extensive narrative regarding physical fitness was presented. It was noted that the individual enjoyed the Zumba fitness program but that the SAP had been discontinued because Zumba was no longer available. It was clarified that, although the Zumba class had been discontinued, the Zumba DVD could be used at the residence. It was again stated that the individual enjoyed the Zumba activity. The narrative then progressed to discussion of whether the individual enjoyed exercise machines, such as a stationary bike. The IDT decided to show the individual the stationary bike to determine interest. The IDT also approved an SAP to teach the individual to sit upon and use a stationary bike. This SAP did not reflect preferences of the individual and was not based upon assessment.<br><br>In addition to the limitations in the ISP process and documents regarding the use of assessments, there were also limitations regarding specific assessment processes. Examples included the following.<br>• Although all SAPs reviewed were presented as having been based upon a task analysis, there was no evidence in the documents provided by the Facility that actual individualized task analyses had been performed. Without an individualized task analysis, it is possible that an SAP could include steps to teach an individual skills they already possessed or begin training at a level that exceeded their | |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
current abilities.<br>
• The Functional Skills Assessment (FSA) had been completed for both individuals. The FSA alone lacks the ability to provide comprehensive assessment and understanding due to a lack of specificity, objectivity and standardization, but could serve as the initial component to a more comprehensive assessment. In neither of the individuals reviewed had additional assessment been attempted. Furthermore, there were indications that the FSA had not been used in formulated decisions about SAPs. For example, Individual #61 had been provided an SAP for brushing teeth. According to the FSA, however, the individual could already perform many steps of the SAP independently.<br><br>
Based upon information provided by RGSC in relation to the two completed ISPs, there was little evidence to suggest that the new ISP process offered meaningful improvement in the use of assessments in the development of skill acquisition programs.<br><br>
<u>Teaching New Skills</u><br>
Teaching new skills requires the use of the same learning principles involved in changing undesired behavior. Therefore, effective skill acquisition programs require many of the same basic components as behavior support plans: Comprehensive assessment of skills and individual resources, the use of formal training methods that include adequate opportunities for training and high levels of reinforcement, an evidence-based and empirical approach to teaching, valid and reliable data collection, and a sound strategy for assessing progress. When one or more of these components are lacking, the ability to provide adequate habilitation services is severely compromised.<br><br>
The seven SAPs provided by RGSC for Individuals #61 and #141 lacked several of the essential components of a skill acquisition program. Furthermore, although in some areas the new SAPs reflected improvement in comparison with previous SAPs, the improvement was modest and limited to only a few of the essential SAP components.<br><br>
<table>
<tr><th></th><th>02/2010</th><th>02/2012</th><th>08/2012</th></tr>
<tr><td>Plan reflects development based upon an individualized task analysis</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Behavioral objective(s)</td><td>0%</td><td>0%</td><td>14%</td></tr>
<tr><td>Operational definitions of target behavior</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Description of teaching conditions</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Schedule of implementation plans for sufficient trials for learning to occur</td><td>0%</td><td>0%</td><td>29%</td></tr>
<tr><td>Relevant discriminative stimuli</td><td>0%</td><td>3%</td><td>57%</td></tr>
<tr><td>Specific instructions</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>
</td><td></td></tr>
</table>

| # | Provision | Assessment of Status | | | | Compliance |
|---|---|---|---|---|---|---|
| | | Opportunity for the target behavior to occur | 0% | 45% | 86% | |
| | | Specific consequences for correct response | 0% | 0% | 0% | |
| | | Specific consequences for incorrect response | 0% | 0% | 14% | |
| | | Plan for maintenance and generalization that includes assessment and measurement methodology | 0% | 0% | 0% | |
| | | Documentation methodology | 0% | 0% | 86% | |

The following specific issues were noted during the review of skill acquisition programs.

Task analysis. Conducting a meaningful task analysis is essential to the development of a skill acquisition program. For many individuals with intellectual and developmental disabilities, tasks and behaviors must be broken down into small, discrete steps that can be more easily learned. Task analysis is the process of breaking complex tasks or skills down into smaller steps in a way most beneficial to the individual who will be provided training. Although all of the SAPs included statements that task analyses were used in the development of the program, no evidence of an actual individualized task analysis was provided for any SAP.

Behavioral objectives. It is essential that efforts to strengthen skills include objectives comprised of observable and measurable elements of the behavior. For only one of the seven SAPs (14%) was the objective stated in measurable and observable terms. This SAP specified that Individual #61 was to point at an oval when asked. Pointing to a single object is a behavior that would be fairly easy to recognize and measure. In a separate SAP for Individual #61, the individual is expected to learn to match coins. Matching coins could mean pointing at similar coins, selecting pictures of similar coins, or pushing two similar coins together. In the case of this SAP, it was suggested that the individual was to push one coin toward a similar coin. In the task steps included in the SAP, however, it is not clear how the two coins would be similar as the steps require matching a penny to coins of different denominations. This matching behavior would be difficult to observe or measure as described.

Operational definitions. In order for training programs to be implemented correctly, it is imperative that the program specifically defines the behavior to be increased. This requirement informs the person implementing the program exactly what behavior the individual is expected to display. Without an operational definition, the risk of strengthening unintended behaviors and slowing the individual's acquisition of skills is increased, since different trainers may prompt and reinforce different behaviors rather than have a consistent requirement. None of the provided SAPs included adequate operational definitions of targets. Rather, in each SAP, the operational definition was

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | stated to be the completion of all steps in the SAP. As noted above regarding the objective to complete the steps in the task analysis, the behavior to be measured was not stated in specific enough terms to represent a, true operational definition.<br><br>Description of teaching conditions. In order for teaching programs to be implemented consistently as intended, the staff implementing those programs must be given explicit instructions including what materials are to be used, how those materials are to be arranged, where training should be conducted and how the environment should be controlled. Without such instructions, training conditions often drift or change across staff and location. As a result, training is ineffective and can strengthen the wrong behavior. Of the training programs reviewed at RGSC during the current site visit, 29% had adequate details to ensure that training could be implemented consistently.<br><br>Sufficient trials. It has been repeatedly demonstrated in research regarding learning that the development of skills requires repetition. In the majority of cases, while the skill is initially being learned, high rates of repetition are required so that the individual is provided multiple opportunities for reinforcement. Often, lower frequencies of reinforcement result in slower rates of learning. If the rate for reinforcement opportunities falls too low in relation to a specific behavior, that specific reinforcement may not compete effectively and efficiently with other reinforcement in the environment. In the majority of skill acquisition programs reviewed at RGSC, the teaching trials were provided at a rate of one per day or less. A single trial per day is not usually sufficient to develop a new behavior or skill.<br><br>Relevant discriminative stimuli. In order for training to be effective, there must be a cue or indication for the learner that reinforcement is available for the completion of a specific task. In four of the seven SAPs (57%), conditions were described in the SAP that could have served as a discriminative stimulus. For an event to actually serve as a discriminative stimulus, however, an SAP must be based upon careful assessment of the individual and the training methodology must be conducted with consistency. At RGSC, there was little indication of adequate assessment in relation to SAPs. Furthermore, the SAPs often lacked instructions of sufficient specificity to ensure that training was conducted consistently. As a result, it was unlikely that the available events or cues truly served as discriminative stimuli in relation to the SAPs.<br><br>Specific instructions. As with the teaching conditions, it is necessary that training be conducted in a consistent and specific manner. Without specific instructions, the trainer may use a different prompt than was intended, offer reinforcement in a different way, or strengthen a behavior other than the behavior to be learned. None of the seven SAPs provided by the Facility included adequate instructions for staff. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Specific consequences for correct and incorrect responses. For learning to take place, it is critical that the person teaching the skill is prepared to use a powerful consequence to reinforce or strengthen correct responses. In all seven of the SAPs submitted for review, verbal praise was listed as the consequence for correct responses. Verbal praise can be a reinforcer. In order to know that verbal praise is indeed a reinforcer, however, a thorough assessment of potential reinforcers must be completed for the individual to be taught. There was no indication that the necessary reinforcer assessments had been completed for either of the individuals for whom the SAPs had been developed; therefore, there was no way to assess whether praise might serve as an effective reinforcer.<br><br>It is also crucial that an appropriate consequence for incorrect responses be identified. By offering an inappropriate consequence for incorrect responses, the trainer could inadvertently strengthen a behavior not essential to the skill being training, reinforce attempts at escaping from training, or even punish the learner for participation in the SAP. Only one SAP, a program for increasing oral hygiene for Individual #141, included an appropriate consequence for an incorrect response. This consequence included prompts and modeling likely to lead to a second, correct attempt by the learner. The remaining SAPs either indicated to attempt the task again without further guidance on how to assist the individual to succeed, or allowed the individual to escape from training.<br><br>Plan for maintenance and generalization. Skill acquisition programs have the ultimate goal of increasing skills in situations outside of the teaching setting. If an individual learns to differentiate colors in the classroom, but does not exhibit that same skill at home or at work or as part of a new and more complex task being learned, then the training has not been fully successful. In order to determine if skills are being used beyond the training setting, it is important that a specific method for monitoring the skill be in place. In the skill acquisition programs reviewed at RGSC, the only plans for generalization were for the IDT to review options when the SAP is completed.<br><br>Implementation of formal and informal skill acquisition training<br>The Monitoring Team conducted observations in a variety of settings across the RGSC campus. The table below reflects the number and percentage of individuals who were engaged in any formal or informal activity that did not include stereotypic movement, self-stimulation, or other undesired behavior.<br><br>| | Staff Present | Individuals Present | Individuals Functionally Engaged | Percent Functionally Engaged |<br>\|---\|---\|---\|---\|---\|<br>\| Classroom 3 \| 1 \| 5 \| 4 \| 80% \|<br>\| Training Room 15 \| 2 \| 6 \| 1 \| 17% \| | |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>501 Foyer</td><td>5</td><td>2</td><td>0</td><td>0%</td></tr>
<tr><td>502 Porch</td><td>0</td><td>3</td><td>1</td><td>33%</td></tr>
<tr><td>501Foyer</td><td>3</td><td>3</td><td>2</td><td>67%</td></tr>
<tr><td>501 Dining Rom</td><td>2</td><td>5</td><td>0</td><td>0%</td></tr>
<tr><td>501 Dining Room</td><td>5</td><td>10</td><td>2</td><td>20%</td></tr>
<tr><td>502 Dining Room</td><td>5</td><td>9</td><td>6</td><td>67%</td></tr>
<tr><td>501 Dining Room</td><td>5</td><td>7</td><td>7</td><td>100%</td></tr>
<tr><td>501 Foyer</td><td>1</td><td>1</td><td>0</td><td>0%</td></tr>
<tr><td>501 Living Room</td><td>1</td><td>1</td><td>1</td><td>100%</td></tr>
<tr><td>502 Foyer</td><td>4</td><td>7</td><td>3</td><td>43%</td></tr>
<tr><td>502 Dining Room</td><td>5</td><td>8</td><td>6</td><td>75%</td></tr>
<tr><td colspan="4">Total percentage of individuals functionally engaged</td><td>49%</td></tr>
<tr><td colspan="4">Percentage of locations with 50% or greater functional engagement</td><td>46%</td></tr>
</table>
<br>Observations revealed that across all settings 49% of observed individuals were functionally engaged. Furthermore, six of 13 settings (46%) of all environments observed reflected at least 50% engagement. It should be noted, however, that the number of observations was substantially limited by the availability of individuals living at the Facility. Several attempts to observe individuals in classroom and vocational settings were unsuccessful as all individuals were absent. It was possible that observations were conducted at poorly scheduled times. Reports from several staff, however, suggested that an unusual number of community trips and activities had been scheduled during the site visit.<br><br>Based upon observations and document reviews, although positive engagement ratings were obtained, it was not possible to determine that individuals were provided with adequate levels of engagement.</td><td></td></tr>
<tr><td>S2</td><td>Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.</td><td>Based upon a review of assessment practices, it was noted that RGSC displayed difficulty in ensuring that individuals received complete and comprehensive assessment as part of the ISP process and training program development. Specific issues related to psychological assessments are presented in Section K of this report.<br><br>As a result of the broad weaknesses in assessment practices at RGSC, as noted in Sections F and K, as well as in Provision S1, it was not evident that the assessments provided adequate measurement of individual abilities or were likely to facilitate the skill acquisition process. Based upon this information, it was not possible to identify any areas of substantial progress in skill or preference assessment at RGSC.</td><td>Noncompliance</td></tr>
<tr><td>S3</td><td>Within three years of the Effective</td><td></td><td></td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:</td><td></td><td></td></tr>
<tr><td></td><td>(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and</td><td>Due to the limitations noted in Provisions S1 and S2, it was frequently not possible to 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 RGSC did not possess a clear measure of each individual's strengths and needs, and could not develop, monitor or revise training programs with accuracy.</td><td>Noncompliance</td></tr>
<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 35 community trips had been taken during the previous six months. In a separate document, the Facility indicated 57 individuals (81% of current population) had participated in community training since the previous site visit. No information was provided by the Facility to reflect the frequency with which each individual was provided community training, the progress that any individual had attained regarding community-based programs, or the integrity with which those programs had been implemented.<br><br><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></table></td><td>Noncompliance</td></tr>
</table>

**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 only 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 and 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 and S3a)
4. RGSC should facilitate among staff the recognition that skill enhancement and behavior change require an empirical, evidence-based approach. (Provision S3a)

| SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs | |
|---|---|
| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. RGSC Self-assessment CV 5 dated 8/13/12<br>2. RGSC Action Plans CV 5 dated 8/9/12<br>3. RGSC Entrance Presentation handout<br>4. DADS Policy 018.1 Most Integrated Setting Practices 3/31/10<br>5. RGSC SOP ICF-MR 200 01 Most Integrated Setting (April 2011)<br>6. RGSC SOP ICF-MR 600 05 Admissions, Transfers, Furloughs and Discharges (April 2011)<br>7. Since last on-site review, a list of all individuals who have been referred for community placement by his or her IDT, including name, date of recommendation and current residential status<br>8. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement. Include name, reason for not being referred, date of request, and current residential status<br>9. Since last on-site review, a list of all individuals who have been transferred to community settings, excluding those whose discharge may be classified as an "alternate discharge<br>10. For the past year, a list of all individuals who have died after moving to the community<br>11. Since last on-site review, a list of all individuals who have been discharged pursuant to an alternative discharge as defined in the Settlement Agreement<br>12. A current list of all alleged offenders committed to the facility following court-ordered evaluations<br>13. For the last twelve months, a list of all individuals who have been assessed for placement, date of assessment, and resulting recommendation(s)<br>14. For the last twelve months, a list of all trainings/educational opportunities provided to individuals, families and LARs to enable them to make informed choices, including but not limited to any self-advocacy activities that address community living options and transition and discharge processes, provider fairs, community living option in-services, and/or on-site reviews of community homes and resources.<br>15. Minutes of meetings of The Advocates (self-advocacy group) for 2/27/12, 3/29/12, 4/24/12, /30/12, 6/26/12, and 7/31/12<br>16. List of group home tours, including names of individuals and staff who toured, 3/16/12-8/24/12<br>17. Since the last compliance visit, a list of all training and educational opportunities that address community living, including but not limited to provider fairs, community living option in-services, and/or on-site visits to community homes and resources provided to Facility staff and a list of staff who participated in those trainings and educational opportunities<br>18. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan developed<br>19. The three (3) most recent Community Living Discharge Plans developed, including the individuals' ISPs, and related assessments that were used in the development of the CLDP and/or were considered |

| | |
|---|---|
| | to be the required 45-day assessments, attendance/signature sheets, and any further documentation of the Facility's efforts to ensure the individual and the family/LAR was informed of the contents of the CLDP<br>20. CLDP for Individual #80, written during the period between submission of this document request and the first day of the on-site review, and cover letter transmitting CLDP to provider<br>21. Since last on-site review, all completed pre-move and post-move monitoring checklists for the 0 individuals who moved to the community, including additional documentation, if any, that reflects follow-up activity taken by the PMM or the sending Facility in response to issues identified in the post-move monitoring checklists. This included Pre-Move Site Review Instruments completed by the Local Authority for Individuals #80 and #115 and Pre-Move Site Reviews completed by the Facility for Individuals #13, #80, #115, and #121.<br>22. Email of 8/17/12 from Michelle Melchor about training provided to staff of provider agency and other issues<br>23. Any facility-wide needs assessments related to the provision of community services to people with developmental disabilities and obstacles to such placement<br>24. The most recent Community Placement Report (inclusive all five components)<br>25. The most recent report of the Facility's analysis of major obstacles to individuals' movement to community living identified by the SSLC.<br>26. Since last onsite review, a list of all individuals returned from a community residential placement, and documentation of the facility's review and assessment of each case<br>27. A list of any individuals who have moved from the facility to the community or for whom the Facility provided post-move monitoring since 7/1/09 and have died.<br>28. Draft DADS Integrated Mortality Reviews process attachment to email from Linda Lothringer of 8/12/12<br>29. For the last one year period, a list of individuals who have transitioned to the community indicating whether or not since their transition, they have: (1) had police contact, and if so the reason why, the date, and an indication of whether or not they were arrested or otherwise detained; (2) had a psychiatric hospitalization, including the date on which they were hospitalized and the length of stay; (3) had an ER visit or unexpected medical hospitalization, including the reason; (4) had an unauthorized departure, including the date and length of departure; (5) been transferred to different setting from which he/she originally transitioned, including both addresses and reason for transfer; (6) died, including the date of death and cause; and/or (7) returned to the facility, including the date of individual's transition to the community, date of return, and reason. Please also include a brief description of any action the facility took with regard to any of these occurrences.<br>30. Community Living/Promoting Independence proposal<br>31. Annual assessments in preparation for ISP planning meetings held during the compliance visit for Individuals #61 and #141<br>32. ISPs developed following ISP planning meetings held during the compliance visit for Individuals #61 and #141<br>33. ISP Attendance Sheet for annual ISP planning meeting for Individual #141<br>34. Documents related to move of Individual #80 for a more integrated setting<br>**People Interviewed:** |

| | |
|---|---|
| | 1. Alma Ortiz, Admissions/Placement Coordinator (APC)<br>2. Staff of Local Authority (LA)<br>**Meeting Attended/Observations:**<br>1. ISP annual planning meetings for Individuals #61 and #141<br>2. Community Living Options Training provided by Local Authority (LA) 8/22/12 |
| | **Facility Self-Assessment:**<br>The Facility provided a self-assessment and action plans. For the self-assessment, the Facility reported for each provision the activities engaged in to conduct the self-assessment, results of the self-assessment, and a self-rating with rationale for the rating. For many of the provisions, the primary or only self-assessment activity was to review the Living Options Monitoring Tools; that had not yet been implemented, so no results were available. It will be important for the Facility not to rely solely on those tools, but also to look at the requirements of the provisions and to develop, where appropriate, objective measures and data that can be integrated into the Facility's quality assurance system. For example, actual data on percent of assessments provided within 45 days of transitions could be gathered, and a sample could be taken of annual assessments from clinical disciplines to determine the percent that include a determination of whether movement to a more integrated setting is appropriate.<br><br>The Facility found that Provisions T1c3 and T1h were in substantial compliance and that the remainder did not yet comply. The Monitoring Team concurs but notes that Provision T1c3 will need additional evidence at the next compliance visit.<br><br>Most items included in the Action Plan were either activities that are ongoing, such as maintaining documentation of contacts related to obtaining legal guardianship, completed activities, or activities "In Process." The Facility needs to develop, for many of these, specific plans and timelines to accomplish those that have not yet been completed. Furthermore, the Facility should use information in this report to identify sequential action steps remaining to achieve compliance with the requirements of the Section, even when actions identified in the Action Plan have been completed. For example, one completed action was "Coordinate Community Exposure Tours." Although a plan has been put into place, the Facility still needs to implement additional steps such as documenting the individual's response to a visit, and tracking the number of tours and of individuals who tour. Other actions are clearer, but it is not clear why the completion dates are not more immediate. For example, the projected completion date for "Begin CLDP at the time of the referral" is 11/1/12. This is an action that could occur easily by simply doing it and preparing drafts. If additional steps are required to accomplish this, they should be included within this action step so they can guide both staff activity and timelines. |
| | **Summary of Monitor's Assessment:**<br>The Facility continued to make progress in encouraging and assisting individuals to move to more integrated settings. In particular, the Facility staff had continued to refer individuals for such movement. At the same time, many people remain on the referral list for an extended time.<br><br>The most serious issue is the need to improve identification of supports needed and inclusion of those in |

| | |
|---|---|
| | the CLDP. This process needs to begin with improvement of identification of supports through the ISP planning process. Although the list of supports in the CLDP of the last individual who moved was more complete than for the others who moved, there still remained important supports that were not identified. Furthermore, these supports were not listed at the time of referral and therefore were not available for the process of selecting a provider and setting. Although CLDPs were available at the time of transition, they were not available in time for review by the Local Authority, provider, individual, and LAR prior to the transition.<br><br>The Facility had improved in providing educational activities for individuals, LARs, and staff, 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.<br><br>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. Nevertheless, the outcome of increased referral indicates that professionals have identified individuals for whom they determine movement to a more integrated setting is appropriate.<br><br>The Facility has begun quality assurance observations of post-move monitoring meetings, but this is recent. Because of the limited description of support needs in the CLDPs, it was difficult to assess the adequacy of the post-move monitoring visits. Observation of one visit identified some supports that were not checked as needed. |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| **T1** | **Planning for Movement, Transition, and Discharge** | | |
| T1a | Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the | The Facility continued to make progress in encouraging and assisting individuals to move to more integrated settings. In particular, the Facility staff had continued to refer individuals for such movement.<br><br>Policies and Procedures related to Movement to the Most Integrated Appropriate Setting:<br>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." The policy's stated purpose was to "prescribe procedures for encouraging and assisting individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the Untied States Supreme Court's decision in Olmstead v. L.C.; identification of | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 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. | needed supports and services to ensure successful transition in the new living environment; identification of obstacles for movement to a more integrated setting; and, post-move monitoring." The policy included components to ensure that any move of an individual to the most integrated setting was consistent with the determinations of professionals that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's ISP.<br><br>RGSC SOP ICF-MR 200 01 Most Integrated Setting repeats the requirements of DADS policy with minor wording revisions to localize it. RGSC SOP ICF-MR 600 05 Admissions, Transfers, Furloughs and Discharges includes a listing of reasons and criteria for discharge as well as responsibilities for actions when community placement "is in the best interest of the individual." It is unclear whether these criteria are consistent with those in DADS policy and with the requirements of Provision F1e regarding the Americans with Disabilities Act and Olmstead finding. This policy also refers to a process called "furlough"; DADS Policy 018 does not include such a process, and the RGSC policy does not define how that process differs from "community placement." The Facility should review this policy to ensure it is required and is consistent with both DADS policy and RGSC SOP ICF-MR 200 01.<br><br><u>Transition Outcomes During Last Six Months:</u><br>• <u>Community Transitions:</u> Four individuals (6%)had transitioned to community living since the last compliance visit. This was an increase of one person compared to the prior six months and reflects continuing improvement in moving individuals to more integrated settings. For three of those four individuals, the period between referral and movement was greater than 180 days; however, this reflected careful planning needed for movement of these three individuals, who wished to live together, and was therefore appropriate and necessary.<br>• <u>Referrals for Community Transitions:</u> The Community Placement Report of 8/10/12 listed 17 individuals on the list of current referrals; since then, one individual had moved to a community home, resulting in 16 individuals (23%) on a waiting list for referrals. The Facility reported that four individuals were referred since the last compliance visit (in addition to the one individual who had been referred since the last compliance visit and had recently moved). One individual on the list had actually moved to community living prior to the last compliance visit but had been readmitted since; nevertheless, the referral date for this individual remained 4/7/11. Of the other 15 individuals, 11 had been on the referral list for more than 180 days. According to the APC, nine individuals had been on daytime visits to community settings and were waiting for overnight visits. Although the number and percentage of individuals on the | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | referral list for more than 180 days is high, this may, in part, reflect the significant effort of the Facility to identify and refer individuals, and to ensure they and their LARs have the opportunity to visit and approve of homes and day programs. Nevertheless, the Facility must make efforts to increase the pace of movement once referral is made.<br>• Positive Outcomes Noted: The Facility made a significant effort to ensure three individuals who wished to live together could do so, although one individual has very significant medical and behavioral support needs. Because this individual moved recently, the outcome of this move and ability to meet the support needs are still not certain. However, the effort of the Facility to address the preferences of the individuals is commendable.<br>• Adverse Outcomes of Transitions:<br>o Returns from Community Placement: Individual #145 had returned from a community setting. At the last compliance visit, the Monitoring Team reviewed the CLDP for this individual and attended a review meeting to discuss concerns with the status of adjustment to community living. Participants at that meeting included staff of RGSC, the provider, the Local Authority (LA, called the Mental Retardation Authority at the time of the review meeting), and the individual's mother. The individual was, at the time, in a psychiatric hospitalization following a lapse in receiving psychotropic medications due to lack of funding, and the meeting was to determine whether the individual would return to RGSC. The determination was that the individual would not return but that the RGSC psychiatrist would consult with the hospital psychiatrist to determine actions.<br><br>The Monitoring Team reviewed the CLDP for the placement and reported in the last compliance report that the individual had initially moved to his family home. Following that move, funding issues led to a lapse in availability of psychotropic medication. It was reported that the community psychiatrist had changed medications although 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 support needed such as follow-up with a psychiatrist and ensuring funding was in place to permit filling the individual's prescriptions.<br><br>The Monitoring Team, in the document request, asked for documentation of the facility's review and assessment of any returns from community living. No information was provided verifying such review in this case. However, as a result of attending the meeting | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | during the last compliance visit, the Monitoring Team was aware that efforts were made to maintain the individual in community living, and that the Facility had the information needed to complete and document such a review, and to identify actions to improve future likelihood of a successful move for this individual and others. The Monitoring Team recommends that such actions be recorded and included in future CLDPs and post-move monitoring as appropriate.<br>o Deaths Following Community Placement: Individual #10 died approximately a year and a half following a move to a community home. Cause of death was related to respiratory failure due to presumed aspiration and/or worsening pneumonia, and to dysphagia. At the time of the individual's move, he was on a ground diet. From the materials provided to the Monitoring Team by the Facility, it was clear that these materials, presumably given to the provider, reported on this diet. However, these materials did not include the list of supports or any documentation of post-move monitoring, so it was not possible to determine what actions the Facility had taken to provide recommendations and training to the provider. As reported in the monitoring report of April 27, 2011, modified diet and food texture was listed in the CLDP as an essential support, and the Facility did verify that essential supports were in place at the time of the move and at following PMM visits, but the Monitoring Team did not have an opportunity to observe a visit for this individual. As these actions were taken early in the compliance review process, they are not relevant to the current compliance review and are provided for information only. A draft policy for integrated mortality reviews would require such reviews for all deaths occurring within one year of transition from a State Center (whereas this death occurred following a longer period following movement to community) ; although that may become a requirement for formal reviews, it would be useful for the Facility to learn from any information provided in order to identify actions the Facility could take to improve planning and follow-up processes.<br>• Other Adverse Outcomes: In response to a document request for a list of individuals who have transitioned to the community indicating whether or not since their transition, they have: (1) had police contact, (2) had a psychiatric hospitalization, (3) had an ER visit or unexpected medical hospitalization, (4) had an unauthorized departure, (5) been transferred to different setting from which he/she originally transitioned, (6) died, (7) returned to the facility, the Facility listed the individuals who had moved and the one individual who had returned. There was no indication that any individuals who had moved since the last compliance visits had experienced | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | any of these adverse outcomes.<br><br>Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting: RGSC continued to engage in many activities during the past six months to encourage and assist individuals to move to the most integrated setting. Since the last compliance visit, the Facility had continued or implemented the following actions and activities:<br>• Local Authority staff attended most ISP annual planning meetings and were available to provide information about more integrated settings.<br>• The LA provides annual training for staff of RGSC. The Monitoring Team attended one of several sessions provided by the LA during the compliance visit; 26 RGSC staff were present. Most participants were direct support professionals (DSPs) from the residential services and vocational services staff, staff who work directly with. Individuals. Training covered the Community Living Options Information Process (CLOIP) and how information is provided to each individual (usually prior to and at the annual ISP staffing), the various types of settings and supports provided in Texas, and answered questions from RGSC staff.<br>• Educational Activities included regularly scheduled tours of community provider settings; both individuals living at RGSC and RGSC staff participate in these. A community provider fair was held during this compliance visit. Further information about these and other educational opportunities is provided in Provision T1b2.<br>• Minutes of meetings of The Advocates (the self-advocacy council) did not reflect presentation since the last compliance visit of training about more integrated settings. Given the outstanding participation and processes described in Provision U, it would be valuable for this topic to be included periodically.<br>• The APC attended most ISP annual planning sessions to answer questions about more integrated settings and to point out issues needing discussion.<br><br>As discussed with regard to Section F, a limited review was conducted of ISPs due to the use of a new format. The revised format specifically required professionals on the team to make an independent recommendation to the individual and his/her guardian. The Facility implemented the new format for the first time at the two ISP annual planning meetings held during the compliance visit. The Monitoring Team observed both meetings and reviewed the ISPs developed following those meetings. Based on this review:<br>• Individual #141<br>o The Living Options discussion was held during the annual ISP planning meeting. A representative of the Local Authority (LA) was present. She reported she had met with the individual on 7/30/12 and presented | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | information including pictures of other settings. The individual had already visited providers nearer to his family. The LA representative emphasized listing supports on the CLDP. When she asked what training the provider staff would need, the CLDP stated she will need to plan the supports. It should be noted that the individual was first referred for movement in September 2011, so a list of supports should already have been drafted.<br>o Of six assessments provided by clinicians, three (50%) provided a recommendation of appropriateness of movement to a more integrated setting. All three determined this would be appropriate.<br>• Individual #61<br>o The Living Options discussion was held during the annual ISP planning meeting. A representative of the Local Authority (LA) was present. She reported she had met with the individual on 5/31/12 and presented information. She reported she had spoken to the individual's family member, who was hesitant about movement but willing to participate on tours. The QDDP stated that last year it was recommended that the individual tour homes, but this had not been done. The LA provided the IDT with different living options. An action plan was developed to tour group homes but did not make a referral pending tours. When the individual was asked where she wanted to live, she state her bedroom.<br>o Of eight assessments provided by clinicians, three (38%) commented on appropriateness of movement to a more integrated setting. Two of these stated movement would be appropriate; the third stated the individual would be available for assessment for movement.<br><br><u>Facility Process to Track and Trend Referral and to Take Improvement Actions:</u><br>The Facility kept a running list of individuals who are in process of referral. Although the Facility did not provide information about formal improvement actions, it continued to implement new processes such as the group home tour process described in Provision T1b2. The Facility should consider developing specific outcome measures related to each of the activities it undertakes for the purpose of encouraging individuals to move to the most integrated setting appropriate to their needs.<br><br>The Facility had made significant progress. The Facility must address more aggressively the movement to more integrated settings of individuals who have been referred and must ensure professionals on the IDT document their recommendations on appropriateness of movement to more integrated settings. | |
| T1b | Commencing within six months of the Effective Date hereof and with | <u>Policies and Procedures:</u><br>There were no changes in policies related to transition and discharge. Refer to Provision | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 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: | T1a for more information. The status of implementation of policies is described below.<br><br>The Facility had continued procedures relevant to transition and discharge and had implemented some new procedures such as the group home tours described in Provision T1b2 and the revised Individual Support Plan format and procedures described in Section F.<br><br>As noted below, these policies and procedures, and their implementation, did not yet fully meet all the requirements of the Settlement Agreement. | |
| | 1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles. | The Monitoring Team reviewed the two ISPs completed in the new format to evaluate compliance with the requirements of this provision.<br><br><u>Identification by the IDT of Protections, Services, and Supports That Need to be Provided in the Most Integrated Appropriate Setting:</u><br>The first sentence of this provision states: "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." Based on an agreement of the parties, substantial compliance with the first sentence of this provision equates to substantial compliance with the following provisions of Section F: Provision F.1.d, which requires Facilities to 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; Provision F.2.a.1, which requires ISPs to address, in a manner building on the individual's preferences and strengths, each individual's prioritized needs; and Provision F.2.a.3, which requires ISPs to integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual.<br><br>As noted above with regard to Section F of the Settlement Agreement, although RGSC had continued to make efforts to improve ISPs, the Facility remained out of substantial compliance with Provisions F.1.d, F.2.a.1, and F.2.a.3. Additional details are provided in the sections of this report that address these provisions.<br><br><u>Obstacles to Movement</u><br>For Individual #141, no obstacles were identified, and referral was continued. For Individual #61, the only obstacle identified was Individual Choice, which the discussion indicated was related to lack of information. Therefore, an action plan was established to tour settings. Although the LA reported that the individual's family was hesitant to have the individual move, and this was identified in the prior year's ISP as an obstacle, it was not listed as an obstacle in this ISP. Discussion indicated the family was willing to participate in tours. No other obstacles to movement were indicated. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • Identification by the IDT of Major Obstacles to Movement:<br>o Obstacles were/were not adequately identified<br>• Identification and Implementation by the IDT of Strategies Intended to Overcome Obstacles:<br>o Training objectives selected for the ISP did/did not address the support needs or barriers identified in the ISP and optimistic living vision (for example, were there employment objectives for people who might move to a living environment that would include work; were there community living skills objectives such as safety skills for people who wish to move to an integrated community environment). | |
| | 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:<br>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:<br><br>An individualized plan for each individual (e.g., in the annual ISP: For Individual #61, an action plan to tour homes was listed in the ISP. Individual #141 had toured homes, and an plan to go on pre-placement visits to a designated group home was established.<br><br>An annual provider fair : A provider fair was held during the compliance visit.<br>• Seven providers participated.<br>• Sign-in sheets documented attendance by 78 staff of RGSC.<br>• The APC reported that all parents and LARs were invited; the Facility did not provide information on the number of families and LARs who attended.<br>• The Facility did not provide information n the number of individuals residing at RGSC who participated. Observation by the Monitoring Team indicated that many individuals attended; they were encouraged to visit each of the providers and receive information.<br>• As this Fair occurred during the compliance visit, there was no information on the effects of the Fair.<br>• The Facility had developed a set of questions for staff and individuals to ask providers. The Monitoring Team did not observe to determine whether staff or individuals used this list but recommends that the Facility interview staff to determine whether the list was helpful and how to improve it.<br><br>Regular SSLC meeting with Local Authorities: Although the Facility did not provide information about regular meetings between the SSLC and the LA, the LA staff reported that the APC attended a meeting of providers hosted by the LA and is scheduled to attend | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | another such meeting in September. These meetings provide an opportunity not only to discuss issues with the LA but also with the local providers. The Monitoring Team recommends that this continue, and that the APC provide information gathered from these meetings to Facility administrators so that any issues needing Facility response or action can be addressed. One example of ongoing communication between the APC and the LA was the development of the weekly provider tour schedule.<br><br><u>Education about community options:</u> The LA carries out The Community Living Options Information Process (CLOIP). According to the APC, the LA provides the information and speaks to families; during the training provided by the LA to RGSC staff, the LA stated that they provide the individual and family information on community living prior to the annual staffing and then discuss at the ISP annual planning meeting if the individual and LAR permit. RGSC did not provide information about any consistent or formalized plan for collecting data on specific outcomes or measures related to education about community living, nor for using such information to evaluate opportunities to improve outcomes. Information about numbers of referrals provides a very important measure, and the continuing increase in referral demonstrates some effect of Facility actions. However, the Facility should seek other ways to measure whether education about community options is producing the desired outcomes. Possible outcomes could include these examples:<br>• Number of individuals and families/LARs who agree to take new or additional actions regarding exploring community options.<br>• Number of individuals and families/LARs who refuse to participate in the CLOIP process.<br>• ISP Action Plans that include goals that target increasing community living skills required for movement to specific providers, or obstacles to movement.<br><br><u>Tours of community providers:</u> The Facility had established and was refining a process for tours of community homes. The Facility provided a list of group home tours from 3/16/12-8/24/12. During that time, there had been 48 separate visits, each involving one individual and one to three staff. A total of 15 individuals participated, 21% of the population. It was not clear that all individuals had an opportunity to go on a tour unless they or their LARs stated they did not want to participate, but this was a much greater level of participation than in past reviews. However, as occurred for Individual #61, action plans for individuals to tour community settings were not always implemented. Furthermore, some individuals went on several tours, which gave them an opportunity to see different settings so that they could make choices. Ten of the 15 individuals were on the referral list, but five had not yet been referred. The APC reported that planning for many of these visits begins at a referral meeting with the IDT, LA, individual, and LAR, at which time possible providers of interest are selected. In July 2012, a new process | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | began in which the LA provides a schedule each week of providers that can be toured; the APC provides a list of individuals for whom the provider might be a good match. Thirty-two of the tours occurred in July and August 2012. The Monitoring Team commends the Facility for implementing this process and will be interested in seeing whether it continues, how many individuals tour, and how the interests of individuals and LARs enters into the decisions about providers to tour. The Facility had developed a set of questions for IDT members to learn about during tours; it would be helpful if a process was developed to disseminate the information learned. Also, the Facility did not provide any information about how staff documented the response of the individuals to these tours. A system should be developed to document response and to provide that information to the IDT.<br><br><u>Opportunities are provided to visit friends who live in the community:</u> The individual who moved had made frequent and regular moves to the home where two other men had moved. Other than that, no information was provided to indicate individuals visited friends who lived in community settings.<br><br><u>Education may be provided at a variety of venues including:</u><br>• Self-advocacy meetings<br>• House meetings for the individuals<br>• Family association meetings, or<br>• Other locations as determined appropriate<br>Because of the high level of attendance and participation, the self-advocacy meetings would provide an excellent opportunity for training. As reported in Provision T1a, training specific to more integrated settings was not provided yet at self-advocacy meetings; the same process being used to provide training on other topics could be used to address a variety of relevant issues. The APC reported that she presented at a parents' association meeting; no agenda was provided to the Monitoring Team.<br><br><u>A plan for staff to learn more about community options that includes:</u><br>• management staff<br>• clinical staff<br>• direct support professionals<br>The primary processes for staff to learn about community options were the tours to community settings, the Provider Fair, and the annual training by the Local Authority. Although it was clear that numerous DSPs and vocational staff participated in all three of these processes, the Monitoring Team did not have information to assess participation by the clinical and management staff. The Facility had developed a set of questions for staff and individuals to ask providers at the Provider Fair, and a list of questions for IDT members to ask regarding community placement selection. Both of those sets of | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | questions could be used to develop and provide information to all staff. The Monitoring Team recommends the Facility consider how to disseminate information learned from the questions, especially the information learned during the tours.<br><br><u>Individuals and families who are reluctant have opportunities to learn about success stories. Some possible opportunities might include:</u><br>• As appropriate, families/LARs who have experienced a successful transition are paired with families/LARs who are reluctant;<br>• Newsletter articles or presentations by individuals or families happy with transition<br>The Facility did not report implementing such activities.<br><br>The Facility had taken many actions to provide education about community settings to individuals, families, and LARs. Continued expansion of these activities, as indicated above, could bring the Facility into substantial compliance. | |
| | 3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices. | The Monitoring Team requested a list for the last 12 months of all individuals who have been assessed for placement, date of assessment, and resulting recommendation(s); in response, the Facility stated "No Change." At the last compliance visit, the Facility reported that assessment occurs during the ISP annual planning meeting.<br><br><u>Assessment Practices Related to Transition and Discharge Policies and Procedures:</u><br>Assessment primarily consisted of discussion during the Living Options Discussion during the annual ISP planning meeting. Observation of two such meetings indicated that such discussion was held. However, the discussion was informal and unstructured; independent determinations and recommendations by professionals on the IDT were not specifically discussed. One individual had been on the referral list for an extended time, and this was continued; discussion was primarily, and appropriately, about review of supports needed and how the process of selection of a provider and transition would occur. For the other individual, the discussion primarily focused on the need for tours for the individual and family.<br><br><u>Percentage of Individuals Assessed as Required:</u><br>The monitoring teams have been discussing this provision item at length with DADS and DOJ. To meet substantial compliance with this provision item, the Facility will need to show that:<br>• Professionals provided their determination regarding the appropriateness of referral for community placement in their annual assessments (this was not yet occurring for all professionals)<br>• The determinations of professionals were discussed at the annual ISP meeting, | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | including a verbal statement by each professional member of the IDT during the meeting (this was not evident in the ISP meetings observed)<br>• Living options for the individual were thoroughly discussed during the annual ISP meeting (this was somewhat evident)<br>• 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 team, including the individual and LAR (this was not yet occurring).<br><br>As noted above, professionals did not consistently make recommendations or determinations regarding referral for community placement in their annual assessments. Discussion of appropriateness was held during the annual ISP planning meetings observed, but for Individual #61, it appeared the decision was driven exclusively by the preference of the family, and there was no documentation or other evidence that the independent recommendations of the professionals on the IDT were discussed. | |
| 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><br>There were no changes reported to policies related to the CLDP. The DADS and RGSC Most Integrated Settings policies govern the development and implementation of CLDPs. The CLDP was to be initiated at the time of referral and was to be updated on an ongoing basis as circumstances required. The APC was responsible for coordination of the CLDP process, in collaboration with the individual's IDT.<br><br><u>Process of Development and Implementation of CLDP:</u><br>The APC reported that she begins gathering the information at the time of referral. At that time, the IDT, LA, individual, and LAR review the location for visits to homes and begin listing the support needs. They do not write the CLDP at that time but gather the information. As tours occur, the team gets together for update meetings to review results of visits and help the individual select a provider. When the selection of provider is made, the CLDP meeting is scheduled; at that time, team members provide assessments completed no longer than 45 days before the CLDP meeting and the APC drafts a CLDP including all supports. Unfortunately, this meant that a written draft that listed all supports identified by the IDT was not available as the visits and referrals to providers occurred. The list of supports is a crucial resource in determining the appropriateness of a given setting and in ensuring a given provider can implement the required supports. Although a CLDP will not be finalized until an individual is accepted and agrees to service in a setting, the Monitoring Team recommends the CLDP be drafted at the time of referral, including a written draft of supports needed, and updated on an ongoing basis. A final CLDP must then be completed before the pre-move site visit to ensure all essential supports are in place at the time of the move. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Timeliness of Development and Implementation of CLDP:<br>The Monitoring Team reviewed CLDPs for all four individuals who had moved since the last compliance visit, Individuals #13, #80, #115, and #121. Dates of CLDP meetings documented on the CLDPs indicated they were held one to two months prior to the date of transition documented in the Profile section on the first page of the CLDP. However, information in the Community Referral Process section for Individual #13 stated the transition was delayed and the actual date of transition was three weeks later; the date of the CLDP meeting was two months prior to the actual transition date, and another meeting was held the day before the transition occurred. For Individual #115, the date of actual transition reported in the Community Referral Process section was nearly a week later than the date listed in the Profile section. It is important to have an actual date of transition on the first page so errors don't occur in other documentation and quality assurance review.<br><br>Documentation was found in the Community Referral Process section of meetings held prior to the CLDP meeting for the purpose of initiating the CLDP process as well as to identify activities needed for selection of a provider. However, although interview with the APC indicated there were periodic update meetings as needed, none of the CLDPs documented more than one such meeting.<br><br>Refer to Provision T1 for a discussion of timeliness of CLDP development regarding Individual #141. A list of support needs had not been developed prior to selection of a home and provider.<br><br>Refer to Provision T1e for information on provision of the CLDP to providers at the time of the pre-move site visit. In two of two Pre-Move Site Review Instruments reviewed, the CLDP was not available at the time of the pre-move site visit.<br><br>Timeliness of Referral and Movement<br>Three of the four CLDPs (75%) documented the time between referral for movement and date of transition was greater than 180 days.<br><br>Development of CLDP in coordination with the Local Authority:<br>All of the four completed CLDPs (100%) provided evidence the LA participated in development of the CLDP. For Individual #80, the Facility provided a meeting attendance sheet that evidenced that the plan was developed in coordination with the responsible LA. For Individuals #13 and #121, the list of recommendations for the transition process made at the meeting included actions to be taken by the LA. For Individual #115, the description of the CLDP meeting listed the LA as participating. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff. | <u>Identification of Essential and Non-Essential Supports:</u><br>Interview with the APC and observation of the ISP annual planning meeting for Individual #141 indicated the process of initiating the CLDP begins with a referral, at which time a planning meeting is held with the IDT, LA, individual, and LAR. Often, this occurs at the annual ISP planning meeting. The APC and Local Authority attend these annual meetings. At the planning meeting, some discussion is held about the supports that will be needed. A CLDP meeting is scheduled when a provider has been selected and funding is approved. At that time, A CLDP meeting is held, and the supports are finalized. The APC brings a draft list of supports needed based on assessments and discussion at meetings.<br><br>The APC and LA were present at the annual ISP planning meeting for Individual #141. A decision was made to refer for movement to a specific home and provider. Discussion was held about support needs, and assignments were made for further assessments to be done. The LA staff asked what training the staff of the home will need; the APC responded that the supports need to be planned. This is the reverse of the appropriate approach in which support needs are identified so that selection of a provider includes assurance that all required supports can be provided. For example, Individual #141 speaks and understands at least limited Spanish, and there is a need for Spanish-speaking staff. This had not been identified or documented as a support needed; the DSP who accompanied the individual on a visit stated there were Spanish-speaking staff, but there is a need to formalize this listing so that visits can include determining whether it is available and the provider can know that this will be required if there is staff turnover, and , following the transition, the post-move monitoring visits include a check to ensure Spanish-speaking staff are available at the home and day program.<br><br>Nevertheless, the process puts most of the onus of identification of support needs on the APC. The IDT as a whole should establish drafts of support needs beginning at the time of referral for movement.<br><br>The identification of supports needed should begin by considering the supports and preferences identified in the ISP. As reported in Provisions F2a1 and F2a3, IDTs did not demonstrate proficiency in overall needs assessment or the identification of the supports and services needed and desired for living in a more integrated setting.<br><br>Review of the four CLDPs, supporting assessments, and ISPs found the following:<br>• Individual #13:<br>o There was little integration of training objectives or service objectives from the ISP into the CLDP. For example, this individual had a service objective to walk for 30 minutes after meals and snacks. The IDT did not include this as a support need in the CLDP. There was no | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | documentation this was considered in the choice of a home or day program.<br>o No non-essential supports (supports needed after, but not on, the day of transition) were listed in the CLDP. This was the case even though the assessments provided for the CLDP included such recommendations as "Yearly ENT exam for hearing loss," and the ISP included preferences and interests such as going out to eat at restaurants that should be included so they can be followed up at post-move monitoring visits.<br>o Although the Speech-Language evaluation reported that most needs and wants need to be anticipated by staff, and the Facility had developed a Communication Dictionary and Communication Strategies for the individual, there was no support listed to train staff of the home and day program on communication strategies used.<br>• Individual #80: This individual has very significant medical, physical management, and behavioral concerns. This was the individual who moved most recently. The specification of supports was more extensive than in the other CLDPs reviewed. For example, unlike the CLDP for Individual #13, this list of supports included a communication picture album to be taken to the new home, and non-essential supports included follow-up appointments with specific health care providers. Nevertheless, concerns remained.<br>o There were significant deficits in the assessments done as part of the CLDP process. For example:<br>▪ The Nursing Assessment did not include health care plans for problems such as constipation (for which the individual has had, according to the Medical discharge summary, several ER visits and hospitalizations over the past year) and was listed on the Active Problem List in the Medical Assessment summary in the CLDP. However, daily and weekly monitoring of bowel movements was listed as an essential support in the CLDP.<br>▪ The OT/PT assessment did not include, in Factors for Community Placement, the need for low pile carpet to minimize falls. Falls could be very hazardous to this individual due to existing medical conditions.<br>▪ The Speech-Language Evaluation did not mention physical and nutritional management (PNM) strategies being trained, although aspects of this plan and training on diet were listed as essential supports.<br>o The CLDP documents included a Person-Directed Plan developed by Tropical Texas Behavioral Health, the Local Authority, dated 7/9/12, before the CLDP meeting of 7/18/12. This plan appeared to be a draft, as many areas to list services and supports were blank. This does | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | indicate a collaborative discussion about support needs occurred during the CLDP development process.<br>o Although there were supports relevant to safe dining and likely parts of the individual's physical and nutritional management plan (PNMP), such as plate guard, built up spoon, and "train staff" of the provide on diet, on diet texture, and on how to thicken fluids, there was not specification of which staff needed training, nor was there a support listed specifically to monitor during all meals/snacks. The support should be described more specifically, either on the CLDP itself or on an attachment. For example, it was unclear whether nurses would be trained on the requirement to give medication crushed with applesauce as part of training on diet or diet texture.<br>• Individual #121<br>o Only four supports were listed—fenced yard, stepping stool, patio, and "Train provider staff on diet and consistency." The individual had a behavior management plan, but the CLDP list of supports did not include training staff, implementing the program, or engaging a behavior analyst to follow the program and periodically review effectiveness.<br>• Individual #115<br>o This individual had a BSP targeting aggression. No relevant support was listed in the CLDP.<br>o The individual was prescribed antiseizure medications, but these were not on the essential supports list, although follow-up with a neurologist was on the non-essential supports list.<br>o Rights assessment documentation listed chopped meat texture, but this was not listed as a support need (although it was included in the Speech-Language assessment summary provided with the CLDP).<br>o Due to underweight, a high calorie diet was recommended. This was addressed on the non-essential supports list, along with "Monitor weight weekly" and follow-up with a dietitian.<br>o The Quality of Life summary listed a preference to attend church and a preference to maintain relationship with family. Neither was listed as a support need.<br><br><u>Specification of Procedures to Monitor Presence of Supports</u><br>For each support, the CLDP contained a column for a statement to be made about how the presence of the support would be checked and when it was due. For three of four individuals (75%), this was completed for all supports (but note that the lists of supports for Individuals #15 and #121 contained very few essential supports and no non-essential supports); for Individual #115, there were no entries in this column. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | For Individual #80, most checks required visual observation for verification. For training, the verification was listed as "Signature sheet." Although a signature sheet to verify training is appropriate, it would be good to have some additional check on competency, such as a competency checklist completed by the trainer to verify the trainee was able to demonstrate knowledge and ability to carry out trained procedures.<br><br><u>Coordination of CLDP with provider staff:</u><br>Four of four CLDPs (100%) contained documentation of involvement by provider staff in the development of the CLDP.<br><br>Three of four CLDPs (75%--Individuals #13, #80, and #121) listed at least one support that involved training provider staff.<br><br>Four of four CLDPs (100%) documented visits to the future home and day program site. In addition, discussion at the annual ISP planning meeting for Individual #141 reported visits to a home where the individual was likely to move, and several individuals on the referral list were waiting for overnight visits before final selection of a home (and most had already had a daytime visit). | |
| | 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><br>In three of four CLDPs (75%), the Facility identified Facility staff responsible for at least one support. In the CLDP for Individual #80, who moved most recently, the Facility identified Facility staff by name for each support.<br><br><u>Completion timeframes for needed actions identified</u>:<br>For two of four CLDPs, only essential supports were listed, so the timeframe was for the day of move. For Individual #115, timeframes were not listed. For Individual #80, timeframes were provided for each support. | 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><br>Because draft CLDPs were not formally prepared, it was not possible to determine whether the individual and, as appropriate, LAR reviewed the initial CLDP. There was documentation that Individuals #80 and #115 attended the final CLDP meeting. None of these individuals had an LAR. For Individual #115, the CLDP documented that his mother attended the CLDP meeting. For Individual #80, there was documentation that a representative of an advocacy agency provided assistance in decision-making and attended the CLDP meeting. The Monitoring Team had been aware since the prior compliance visit that the advocacy agency was actively involved in consideration of a move for Individuals #13, #80, and #121. | Substantial Compliance |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The Monitoring Team was not provided information to assess participation and/or information to individual/LAR when revisions to CLDP were made, other than the final CLDP meeting.<br><br>The Facility should identify a means to document, on an ongoing basis, revisions in CLDPs and the involvement of the individual and, as appropriate, LAR in those decisions.<br><br>This provision was found in compliance at the last two compliance visits. The Monitoring Team is unsure whether there was a change in the availability of documents, or whether there was actual change in review by the LAR and individual. Because the individuals were involved in the ISP annual planning meetings observed, and because the Monitoring Team was made aware of consistent involvement of an advocacy organization in planning and implementing moves for three individuals, this provision is being rated as in substantial compliance. However, for it to remain in substantial compliance at the next compliance visit, there must be evidence that draft CLDPs (or, at a minimum, lists of supports needed) are provided to individuals and LARs for review as they are developed and revised, and there must be documentation of contacts and meetings throughout the development and revision process.</td><td></td></tr>
<tr><td>T1d</td><td>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.</td><td><u>Timeliness of Assessments:</u><br>A process was in place to identify the assessments required and track them for completion. Four of four CLDPs (199%) included a table of assessments or updates needed, person responsible, and date for completion. However, some assessments were either not completed or not provided along with the CLDP as requested. The table below shows the rate of completion or updating of assessments.
<table>
<tr><th>Individual</th><th>Number of assessments or updates</th><th>Number completed within 45 days of transition</th><th>% completed within 45 days of transition</th></tr>
<tr><td>#13</td><td>6</td><td>5*</td><td>84%</td></tr>
<tr><td>#80</td><td>8</td><td>7*</td><td>88%</td></tr>
<tr><td>#115</td><td>11</td><td>10</td><td>91%</td></tr>
<tr><td>#121</td><td>7</td><td>5*</td><td>71%</td></tr>
</table>
* All assessments provided with the CLDP were timely except for one assessment for Individual #115. Any identified as not completed were not found in the assessments provided.<br><br><u>Adequacy and Comprehensiveness of Assessments:</u><br>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 support needs both during an individual's residence at the Facility and as part of</td><td>Noncompliance</td></tr>
</table>

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | transition to a more integrated setting.<br><br>Two individuals experienced adverse outcomes following movement.<br>• Individual #145 returned to RGSC. Because this individual's CLDP and assessments were completed prior to the last compliance visit, the Monitoring Team did not review those for this provision. However, the Monitoring Team recommends that the Facility complete an in-depth review of the reasons for return and identify, as part of that review, whether assessments identified all issues that could have contributed to the return.<br>• Individual #115 sustained a fracture during a behavioral incident at the day habilitation site. Following hospitalization, the individual moved from the community residence to his mother's home and had changed to a different day habilitation site. | |
| T1e | Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility. | <u>Local Authority Continuity of Care Process:</u><br>As part of the document request, the Monitoring Team asked for a list of all pre-move and post-move monitoring visits, and completed checklists for the last 10 individuals who moved to the community. The Facility provided Pre-move Site Review Instruments completed by the LA for Individuals #13 and #115, but not for Individuals #80 and #121. Therefore, the Monitoring Team could review these checklists for only half the individuals who moved and could not verify that pre-move visits were conducted or the comprehensiveness and accuracy of the checks for all individuals. The Monitoring Team had visited the selected home for Individuals #13, #80, and #121 during the last compliance visit and was able to verify that many of the physical supports listed were in place, but others were not yet completed.<br><br>Pre-move Site Review Instruments reviewed were completed within required timeframes. These instruments were standardized forms that did not review specific supports for individuals but did determine whether the site administrator/manager had a copy of the individual's draft CLDP. For Individual #80, the instrument documented that the site administrator did not have a copy of the draft CLDP and provided, as explanation, that the APC stated that she was still pending information on the BSP to complete the CLDP. No plan of action was documented. For Individual #115, the checklist also documented that the draft CLDP was not provided and had not been finalized, but stated that a copy would be provided when completed.<br><br><u>Pre-Move Site Visit Completed by Facility:</u><br>The APC was designated as the responsible Facility staff for completion of the Pre-Move Site Visit. No such visits were conducted during the compliance visit, so the Monitoring Team was not able to observe the process but rather relied upon documentation to | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | assess compliance. The Monitoring Team reviewed pre-move site reviews conducted by the APC for all four individuals who had moved. Pre-move site visits were made to the homes to which people moved, but there was limited indication that pre-move site visits were made to the day programs. For example, for Individual #13, the indication that the Day Program had been visited simply stated, "APC had previously visited the Day Program and the place is in good repair and activities were happening in all areas" but did not indicate whether all required supports were available. However, an email from Michelle Melchor described training provided the morning of 8/17/12 for staff from the home and day program. It would be helpful for the APC to identify which areas were checked.<br><br>For Individual #121, the information checked for the pre-move site visit was limited because the list of supports was limited. For the other three individuals, there was documentation that each support was checked. However, checks for these individuals also did not ensure that all supports needed were available at each site. For example, for Individual #80, one support was "built-up spoon"; evidence of availability was that the spoon will be at the home, and documentation from the pre-move site review documented that the spoon was transported on the day of the move. No consideration was documented of the need for a spoon to be available at the day program for lunch, and no documentation was provided on the pre-move site review document that the availability of the spoon at the day program was checked.<br><br><u>Availability of Supports at Time of Move</u><br>Pre-move site reviews documented that all essential supports were in place. As noted above, this process is limited by the comprehensiveness and clarity of the lists of supports needed. | |
| 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. | <u>Quality Assurance Processes to Ensure Development of CLDPs:</u><br>Responsibility for ensuring CLDPs were complete and comprehensive, and that assessments were completed, fell to the APC. However, as indicated by the lack of availability of CLDPs, this was not an effective process. The Facility needs to implement more formal processes to monitor and ensure development of CLDPs.<br><br><u>Quality Assurance Processes to Ensure Implementation of CLDPs:</u><br>The pre-move site review provided a layer of scrutiny to ensure that essential supports were in place prior to an individual leaving the community. The Monitoring Team commended this initiative, as the existing LA pre-move site visit did not focus on ensuring specific individual supports were in place. As described under Provision T1e, however, implementation of the pre-move site review did not clearly document that all required supports were available in all settings where they were needed. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | The Facility began a process of having a quality assurance observer accompany the APC when she did post-move monitoring visits.<br><br>RGSC should consider formalizing the quality assurance processes for ensuring development and implementation of CLDPs, including development of quality assurance data. | |
| T1g | Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature. | <u>Obstacle Information Gathered:</u><br>Activities at the Facility and State levels demonstrated progress towards substantial compliance with this provision item. The State issued the *Annual Report: Obstacles to Transition Statewide Summary, Fiscal Year 2011*, with data current as of 8/31/11.<br><br>RGSC collected data on obstacle information through the ISP process, using a list of DADS-specified obstacles. Data provided to the Monitoring Team about obstacles was found in the RGSC *Annual Report: Obstacles to Transition* for FY 2011, dated 8/31/11, which was included in the DADS report. The Monitoring Team request for a printout of the database/report summarizing obstacles, but the response was this 2011 report.<br><br>As explained in the last monitoring report, this 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. The Monitoring Team looks forward to receiving updated data at the next compliance visit.<br><br><u>Annual Obstacle Analysis by Facility:</u><br>The *Annual Report: Obstacles to Transition, Rio Grande State Center* for Fiscal Year 2011 provided data on population, separations, referrals for community transition, and obstacles to community transition. The total number of obstacles reported was 20. With a population of 70, and 15 people on a referral list for movement, the updated data should show obstacles to movement for 55 individuals.<br><br>The report accurately stated that the number of referrals had increased in FY 2011 compared to prior years. Action plans were developed to address some issues; one action that has been implemented was an increase in visits to community group homes scheduled by the LA.<br><br><u>Appropriate Steps Taken by DADS to Overcome or Reduce Identified Obstacles:</u><br>DADS took steps to overcome or reduce the obstacles that had been identified, including:<br>▪ DADS created a report summarizing obstacles across the state, and included the Facility's report as an addendum/attachment to the report. The statewide | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | report was dated October 2011.<br>▪ The statewide report listed the 13 obstacle areas used in FY11. DADS was planning improvements to the way it categorized and collected (and the way it had the Facilities collect) data regarding obstacles.<br>▪ DADS indicated actions that it would take to overcome or reduce these obstacles:<br>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.<br>o DADS did not, but should, include a description regarding whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS).<br><br>The Facility should soon be submitting its annual report to the State, which should include an analysis of data collected thus far. | |
| T1h | Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an | The Facility provided a Community Placement Report covering 2/1/12-7/31/12 for current referrals, rescinded referrals, and community placements, and covering 9/1/10-8/10/12 for individuals/LARs preferring community placement but not referred.<br><br>The report listed:<br>• Current referrals: 17 individuals were on the list, but Individual #80 had moved immediately prior to this visit.<br>• Community placements: 3 individuals were on the list.<br>• Rescinded referrals: 2 individuals had rescinded referrals. These were noted as IDT decisions, one due to medical and the other due to behavior/psychiatric issues.<br>• Individuals prefers community—Not referred—LAR Choice: No individuals were in this category.<br>• Individual prefers community—Not referred—other reasons: 2 individuals were in this category, one for legal issues and the other for citizenship/funding issues.<br>• LAR prefers community—not referred: No individuals were in this category.<br><br>The Monitoring Panel asked that a final category be added that includes a list of names of | Substantial Compliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 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. | 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 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 | <u>Staffing</u><br>Alma Ortiz, Admission/Placement Coordinator, conducted post-move monitoring.<br><br><u>Timeliness of Post-Move Monitoring Visits</u><br>Post-move monitoring documentation was reviewed for three individuals, each of whom had moved more than 90 days prior to the compliance visit. Nine of nine required visits (100%) were conducted timely.<br><br><u>Use of Standard Assessment Tool:</u><br>All monitoring was completed using the Post-Move Monitoring Checklist. The forms for Individual #115 were different from those for Individuals #13 and #121. Although it contained most of the same information, not all information was found on this form; for example, it did not list adaptive equipment.<br><br>For Individuals #13 and #121, the 7-day observation occurred only at the day habilitation program. The 45-day and 90-day visits were documented as occurring at both the residence and the day habilitation site.<br><br>For Individual #115, the 7-day visit occurred at a hospital, the 45-day visit including observation at the individual's residence at his mother's home and an attempted observation at the day habilitation site (the individual had gone on an outing), and the 90-day visit at the mother's home but with no documentation of an observation at the | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | appropriate MRA or regulatory agency. | day habilitation site.<br><br>The Facility should ensure that each post-move monitoring visit includes observations at all sites where the individual receives services.<br><br><u>Assessment of Presence of Supports Called for in CLDP:</u><br>All 3 (100%) post -move monitoring visits were documented in the proper format.<br>• Post move monitoring report forms were completed correctly and thoroughly. Each support was documented as checked with either a yes or no (Individual #115) or a comment.<br>• The overall summary at the end of the post move monitoring reports was good to see.<br><br><u>Facility's Efforts to Ensure Supports are Implemented:</u><br>Because the new format of the Post-Move Monitoring Checklist used comments rather than a Yes/No checklist, it was difficult to determine whether some supports were present. For example, for Individual #13, the comment for all checks for "Train staff on diet consistency" was "None." The same comment was made at all checks for Individual #121 for "Patio." While it was clear from pre-move site review that training checklists were provided and a patio was present, it was certain that the patio remained at the home but more likely that there had been turnover at the home or day habilitation program that would require additional training. The Monitoring Team recommends that a statement be made for each support as to whether it was in place. Furthermore, for supports that may be present or not at each separate review, it is important to check the presence each time.<br><br>For Individual #115, all essential supports were available at the 7-day visit. However, at both later visits, "stress ball" was not present, and follow up appointments with a dentist and dietitian had not been made. The APC reported that the individual's weight had increased (presumably indicating that there was no need to see the dietitian) and recommended in the summary that the IDT discuss the medical appointments but did not list that in "Recommendations to PST for follow-up." No follow-up was documented about the stress ball, but the summary indicated that the individual was doing well, and this was not referred to the IDT for review. It is important that any supports not present be discussed with the provider and IDT, as well as the individual and LAR when appropriate, to make decisions about revision to the list of supports needed.<br><br><u>Barriers to thorough PMM Review:</u><br>The APC was responsible for admissions, placements, development of CLDPs, and pre- and post-move monitoring. This likely limited her time to work with IDTs to ensure supports were adequately described, and therefore meant that the PMM reviews were | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | somewhat limited. A transition coordinator is being assigned to RGSC, which should free the APC to improve identification of supports, which should make PMM reviews more thorough. Even if more time is available, though, it will be important to ensure processes are clear, standardized, and implemented to ensure all supports are reviewed thoroughly and that the IDT is involved as necessary. | |
| 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><br>The Monitoring Team observed the PMM 7-day visit for Individual #80. Monitoring visits were made to the home and day program areas. The APC was accompanied by a quality assurance monitor, a recent practice that was reported to be planned for each PMM visit. In general, the APC looked at the supports listed in the CLDP, asked questions of staff at both sites, looked at general conditions at both sites, and did a thorough review. However, there were some items missed. The PMM did not:<br>• Look at training sign-in sheets or confirm that there were no untrained staff working with the individual.<br>• Check for the wheelchair due on the day of the visit; she did not have the non-essential support list with her.<br>• Check incident reports or other documentation of scratches the individual had.<br><br>The provider staff pointed out that the Facility sent minimal clothing with the individual. Although this was not, and would typically not be, included in the CLDP, it should be routinely a part of the transition process. The APC stated she would follow up with the IDT.<br><br>Lists of all supports should be brought to each PMM visit, and all need to be checked. In particular, training checklists (or, if the CLDP were written to ensure actual competence, questioning of staff) should be checked if there are any staff who were not involved at the time of the original move. In this case, the 7-day visit, that was unlikely, but it should still be checked. | Noncompliance |
| **T3** | **Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in | | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 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:<br>(a) individuals who move out of state;<br>(b) individuals discharged at the expiration of an emergency admission;<br>(c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe;<br>(d) individuals receiving respite services at the Facility for a maximum period of 60 days;<br>(e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission;<br>(f) individuals discharged pursuant to a court order vacating the commitment order. | No individuals were discharged pursuant to an alternative discharge. | Not Rated |

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

1. Review RGSC Policy 600 05 Admissions, Transfers, Furloughs and Discharges to ensure it is required and is consistent with both DADS policy and RGSC SOP ICF-MR 200 01. (Provision T1a)
2. Document findings of reviews of cases in which an individual returns from an unsuccessful move to a more integrated setting so they can be used to improve CLDP planning and the PMM process when appropriate. (Provision T1a)
3. The Facility should consider developing specific outcome measures related to each of the activities it undertakes for the purpose of encouraging individuals to move to the most integrated setting appropriate to their needs. (Provision T1a)
4. The APC should provide information gathered from the provider meetings hosted by the Local Authority to Facility administrators so that any issues needing Facility response or action can be addressed. (Provision T1b2)
5. Develop a process to document response of individuals during tours of community settings and to provide that information to the IDT. (Provision T1b2)
6. Periodically include on the agenda of meetings of The Advocates a topic about community living opportunities. (Provision T1b2)
7. The CLDP should be drafted at the time of referral, including supports needed, and updated on an ongoing basis. The IDT as a whole should establish drafts of support needs. (Provisions T1c and T1c1)
8. The Facility should identify a means to document, on an ongoing basis, revisions in CLDPs and the involvement of the individual and, as appropriate, LAR in those decisions. (Provision T1c3)
9. Complete an in-depth review of the reasons for on individual's return from community living and identify, as part of that review, whether assessments identified all issues that could have contributed to the return. Develop a process to review adverse outcomes of moves occurring within one year following the move, including root cause analysis and review of all pre-move assessments and supports listed. (Provision T1d)
10. Implement more formal processes to monitor and ensure development and implementation of CLDPs. Consider formalizing the quality assurance processes and including development of quality assurance data. (Provision T1f)
11. The Monitoring Team recommends that a statement be made for each support as to whether it was in place at the time of each Post-Move Monitoring visit. (Provision T2a)

| SECTION U: Consent | |
|---|---|
| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. RGSC Self-assessment CV 5 dated 8/13/12<br>2. RGSC Action Plans CV 5 dated 8/9/12<br>3. RGSC Entrance Presentation handout<br>4. Section U Presentation Book<br>5. DADS Policy 019: Guardianship, effective 3/7/12<br>6. RGSC Standard Operating Procedure (SOP) ICF-IID 200 04 Process for Reviewing the Need for Guardianship, April 2012<br>7. DADS Policy 057 Self-Advocacy and Exhibit A: Meeting Agenda Template 5/30/12<br>8. RGSC SOP ICF-IID 200 09 Self Advocacy Program—The "Advocates" July 2012<br>9. Need for Guardianship Record 7/23/12<br>10. Email from Alicia Alaniz to attendees of the meeting to re-rank and prioritize guardianship<br>11. Minutes of the RGSC JCAHO Ethics, Rights, and Responsibilities Team of 2/15/12, 3/28/12, 5/16/12 and 7/18/12<br>12. Minutes of meetings of The Advocates (self-advocacy group) for 2/27/12, 3/29/12, 4/24/12, /30/12, 6/26/12, and 7/31/12<br>13. Agenda for the RGSC-Parents' Association meeting of May 5, 2012<br>14. Email from Shaun Bickley of Arc of Texas to Alicia Alaniz about SAVE Grant training, 6/27/12<br>**People Interviewed:**<br>1. Alicia Alaniz, Human Rights Officer (HRO)<br>2. Liza Pena, HRO<br>**Meeting Attended/Observations:**<br>1. The Advocates (Self-Advocacy group) meeting of 8/29/12 |
| | **Facility Self-Assessment:**<br>The Facility provided a self-assessment and action plans. For the self-assessment, the Facility reported for each provision the activities engaged in to conduct the self-assessment, results of the self-assessment, and a self-rating with rationale for the rating. The activities engaged in included review of policy, review of individuals' need for guardianship, and a Guardianship Priority Tool and Guardianship Ranking Tool (following the visit, the Monitoring Team was informed that these were the same; no such tool was provided to the Monitoring Team, but this appears to be the listing of criteria for establishing level of need), review of potential referrals and guardianship contacts, and review of attempts to seek guardians or advocates. The Facility found neither provision to be in compliance.<br><br>For Provision U1, the Facility self-assessed that the Guardianship policy had been finalized and trained, that all individuals were reviewed for Guardianship Priority, and that the Guardianship Priority Tool is current and useful. Nevertheless, the Facility rated noncompliance because a formal process to determine functional capacity has not been finalized. The Monitoring Team concurs. However, the Facility also stated it is not in compliance "as all individuals do not currently have a legal guardianship"; the Settlement Agreement does not require that all individuals have a legal guardian, and structured review of capacity to |

| | |
|---|---|
| | make decisions may identify individuals who do not need a legal guardian.<br><br>For Provision U2, the Facility self-assessed that all individuals were prioritized per the Guardianship Ranking Tool, that all potential referral to families had been addressed via telephone calls and mail (resulting in six potential family members who have initiated the process to gain legal guardianship), that the HRO had completed training facility personnel on the policy, that a formal report of contacts was presented monthly at the Settlement Agreement Performance Improvement Council (SA-PIC) meeting, and that requests for information from local organizations are pending. The Facility rated noncompliance as it postulated that many individuals continue to demonstrate a need for a legal guardian or advocate. The self-rating also included information on attendance at self-advocacy meetings; this was not listed as an activity engaged in to conduct the self-assessment but would be valuable to include.<br><br>The Facility also provided an Action Plan for moving toward compliance with requirements of this Section. Most items included in the Action Plan were either activities that are ongoing, such as maintaining documentation of contacts related to obtaining legal guardianship, or are completed activities. Some actions, such as contacting other SSLCs to request their guardianship monitoring tools, are reported to be in process. Although many valuable activities were listed, it might be helpful to aggregate activities that are related to a specific process or outcome, so it can be clearly seen whether all needed actions are taken. For example, all activities related to assessing capacity to make decisions could be aggregated, including identifying processes and tools, selecting processes and tools, piloting these, training staff, and monitoring implementation and effect. |
| | **Summary of Monitor's Assessment:**<br>The Facility determined that it was not yet in compliance with either provision of this Section. The Monitoring Team concurs. The State and Facility have made progress toward compliance with Provision U1 by establishing policy, and developing and revising a list that prioritizes individuals' need for guardianship and a process for ongoing semiannual review.<br><br>Additional clarity is needed to resolve possible inconsistencies in the policy, and the Facility must ensure the committee assigned as the Guardianship Committee meets the requirements of DADS policy.<br><br>Neither the Facility nor 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 the individual cannot make, or needs assistance to make, such decisions. The Facility had begun investigating approaches to assessing capacity of individuals to make decisions. The Monitoring Team commends the Facility on beginning this process. Observation of annual ISP planning meetings and review of Individual Support Plans (ISPs) developed at those meetings indicated that consideration of capacity of individuals to make decisions remains brief if it occurs at all, although staff knowledge of individuals and information from assessments provided good information when such consideration was made.<br><br>The Facility was making efforts to obtain guardianship. Prior to the last compliance visit, 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 to families and advocates to inform them. Although no guardianships had yet been established through these, progress was being made, and additional families have been identified to use this process.<br><br>The Facility has established remarkable participation by individuals in a self-advocacy group. Not only do more than 40% of individuals attend, but also participation by most attendees is active. Structured training is provided at each meeting on issues such as abuse and neglect, and privacy. In addition, the Facility was in process of working with the Arc to present a training on self-advocacy to individuals residing at RGSC and to community advocates.<br><br>Compliance will require full implementation of the Guardianship policy, development of a structured process to assess capacity to make decisions, more complete IDT review and discussion of individuals' need for rights restrictions with capacity to make such decisions being addressed in the discussions, and greater success in gaining needed guardianships. |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| U1 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources. | <u>Policies and Procedures related to functional capacity to give consent and/or prioritization of need for LAR:</u><br>DADS issued Policy 019: Guardianship, effective 3/7/12, with five Exhibits. The stated purpose of this new policy was "to ensure that individuals residing in State Supported Living Centers (SSLCs) and their legally authorized representatives (LARs) and correspondents are made aware of guardianship services available in Texas and to identify those individuals without a LAR who would benefit from having an LAR to help them make decisions regarding treatment and programming." This policy provides procedures to coordinate guardianship services, to identify individuals in need of guardianship, to prioritize need for guardianship, and to make efforts to obtain guardians. The policy does not provide substantial guidance to the Facility and the IDTs in how to assess an individual's decisional capacities and/or need for substitute decision-making or assistance in decision-making.<br><br>Policy 019 addressed requirements pertinent to Provision U1, including the development and maintenance of a prioritized guardianship list of individuals who "Do not have the functional capacity to make decisions regarding their own health or welfare; and Do not have an existing LAR to make such a decision." The policy stated the IDT would prioritize the guardianship list but also assigns responsibility for "developing, prioritizing and maintaining" the list to a Guardianship Committee. Exhibit A: Procedures also indicates it would be the responsibility of the Committee to do the prioritization. DADS should clarify its intent. Policy 019 requires updating of the guardianship list semiannually. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Policy 019 (in section I on Guardianship Coordinator) states "Members of the Guardianship Committee should include existing LARs, interested family members, correspondents, individuals receiving services at the facility, staff, and impartial members of the community as appropriate."<br><br>The prioritization criteria contained in Policy 019 are identical to the requirements in the Settlement Agreement (SA). The Policy provides four criteria: determined to be least able to express wishes or make determinations regarding health or welfare, comparatively frequent need for decisions requiring consent, comparatively most restrictive programming, and having potential guardianship resources. Priority levels were based on umber of criteria that pertain to each individual. Priority I was to be assigned to individuals who met three of the criteria, Priority II to those who met two criteria, and Priority III to those who met one criterion. Exhibit A: Procedures calls for the Guardianship Committee to consider the following criteria: whether the individual has an actively involved person to advocate for him or her; a pattern of injury, abuse or neglect; receives or is proposed to receive a restrictive program; receives psychoactive medication; has serious, ongoing medical needs; and/or has severely impaired communication. It was not clear how these two sets of criteria were meant to be integrated. DADS should clarify its intent in regard to these criteria as well.<br><br>The Monitoring Team remained concerned that the new policy, while requiring IDTs to make an assessment of an individual's decisional capacities, provided little to no guidance as to how this assessment should be accomplished. In fact, the policy described only "functional capacity to make decisions" without consideration of the possibility that individuals may have capacity to make decisions about some areas of life but not others, or may be able to make decisions with assistance. The policy did not address the standardized tools or methodology IDTs should use to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making. Facility IDTs continue to need guidance and training from DADS to prescribe a process for how an assessment should be accomplished to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. Without such guidance, facilities run the risk of inappropriately identifying need for guardianship that, if acted upon, could result in an individual unnecessarily losing rights to make and/or participate in his or her own decisions.<br><br>The statewide policy also called for the HRO to maintain data, including a list of individuals without an LAR; names and priority levels of individuals referred to the Guardianship Committee; status of the referrals; and dates guardianships were secured. These data were to be entered into a DADS statewide database. In addition, the Facility was to make monthly progress notes regarding the status of individuals referred to the Guardianship Committee. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | RGSC had localized the DADS policy in RGSC SOP ICF-IID 200 04 Process for Reviewing the Need for Guardianship; this had been updated and revised in April 2012. To operationalize the policy for the Facility, RGSC had done the following (among other policy requirements):<br>• Established that the IDT and QDDP are responsible to assess need for guardianship at the 30 day program planning conference and review annually (at annual staffing) and at the second quarterly review or sooner. The Human Rights Officer stated that the plan is also to have a reassessment and following any hospitalization.<br>• Appointed the Human Rights Officer (HRO) to be the Guardianship Coordinator, as required by Policy 019.<br>• Established the Joint Commission Ethics, Rights, and Responsibilities Team to be the Guardianship Committee. It was unclear that composition of this committee would include, at least for purposes of developing the prioritized guardianship list, "existing LARs, interested family members, correspondents, individuals receiving services at the facility, staff, and impartial members of the community as appropriate." The Facility must ensure the composition of the assigned committee meets the requirements of Policy 019 for the Guardianship Committee. Following the visit, the Monitoring Team was informed that an action plan was generated, and revisions to this policy were pending and require approval from DADS.<br>• Requires that the priority list be updated by the HRO at every annual and second quarterly staffing with all disciplines participating in the ranking. As noted with Policy 019, it is unclear how the rankings done by the HRO (with the IDT) were to be integrated with those done by the Guardianship Committee.<br><br>The RGSC SOP did not include the DADS requirement to document, in a monthly progress note, the status of individuals referred to the Guardianship Committee but otherwise included all requirements of Policy 019.<br><br><u>Development and Maintenance of Prioritized List:</u><br>The Facility maintained a prioritized list, using prioritization ratings from one (most in need) to three (least in need). This list was developed by a workgroup that included the ICF-IID HRO (who chaired the group), the MH HRO, QDDPs, clinical director, several clinicians from a range of disciplines, and home supervisors. Although Policy 019 identifies both the IDT and the Guardianship Committee as responsible for this listing, the JCAHO Ethics, Rights and Responsibilities Committee had not yet met to begin this role. As reported by the HRO, updating of this list will be done by the IDTs with assistance from the HRO. It was unclear what role the assigned committee will have in | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | this process, but the HRO reported the committee would receive training at its next meeting in September 2012.<br><br>The workgroup used the ranking criteria provided in DADS Policy 019 and RGSC SOP 200 04.<br><br>The Monitoring Team reviewed the Priority List, dated 7/23/12. Of 71 individuals on the list (which included one individual who moved between 7/23/12 and the beginning of the compliance visit) 35 (49%) were rated as Priority I compared to the same number at the last compliance visit (but only eight at the prior semiannual ranking), 11 (15%) were rated as Priority II compared to 13 at the last compliance visit, and one was listed as Priority III compared to two at the last compliance visit. Twenty-four (34%) individuals were ranked as non-priority compared to 21 at the last compliance visit.<br><br><u>Assessment of Functional Capacity to Render a Decision</u><br>The Facility did not routinely use standardized or validated instruments and/or structured processes to assess functional capacity, so the decision to place someone on the prioritized list was still without a sound basis for the most part. RGSC SOP 200 04, following DADS Policy 019, requires that need for guardianship be assessed at the 30 day program planning conference (following admission) and reviewed annually at the annual staffing, or sooner if necessary. The SOP does not provide guidance as to how this assessment should be done or what criteria should be addressed. The HRO had sought information on possible assessments and had received a format used in a VA mental health program and a proposal from staff of the mental health program at RGSC. This effort to identify useful and appropriate measures was commendable.<br><br>The ISP for Individual #141 recorded the IDT discussion of capacity to render a decision during the annual ISP planning meeting. Most discussion was very brief and simply stated that the individual is not able to give consent. However, the HRO raised the issue of whether there is truly a need for a money restriction as planned by the IDT. Extensive discussion of this specific issue was held. Although no assessment was done or planned using standardized or validated instruments, the discussion included questions about several aspects of the individual's ability to manage money, with information provided from Direct Support Professionals (DSPs) about the individual's typical use of money and from clinical assessments about the individual's skills. Following this discussion, the IDT chose to remove the restriction on the money the individual could keep with him from his weekly earnings. Although there was no assessment using validated instruments, the discussion revealed that the IDT was able to provide a range of useful information. This discussion was limited to money management, and similar discussion should be held regarding capacity to make decisions in other areas. Following this discussion, the IDT discussed the individual's level of need for guardianship. Criteria from the guardianship | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | policy were used to establish the rating. Again, no validated instrument or other structured assessment tool was used. Discussion was brief and focused on communication and availability of someone to take on guardianship. The Action Plan document for this individual seemed incomplete, as there were Skill Acquisition Plans (SAPs) that were not reflected in the Action Plan. Neither the Action Plan nor SAPs included any evidence of training to increase capacity to make decisions.<br><br>The ISP developed from the planning meeting for Individual #61 did not record discussion but did provide rationale for restrictions. There was no evidence that any structured approach was used to determine capacity to make decisions. Although the ISP stated that the individual can express wishes, it also stated the individual "is not able to provide consent with programmatic, financial, release of records, media/photo, restrictive practices." Rationales were provided for restrictions on "Fluid restriction," "1;1 (sic) at hospital," Individual Support Plan (ISP)," "Money management," and "Behavior." Rationales did not provide any indication of assessment of the individual's capacity to make decisions on any of these issues. The ISP did report that the individual's family is in process of "becoming a LAR." It also noted that the individual has participated in self-advocacy meetings but did not report on her level of participation or how that might affect assessment of capacity to make decisions. The Action Plan and an SAP addressed the restriction on money management.<br><br>The Monitoring Team also attended the HRC meeting held during the week of the compliance visit in which the committee reviewed the Rights Assessments. As reported in Provision K9, there were numerous instances in which individuals could not be reviewed in a timely manner due to delays in completing and submitting necessary documentation. While not specifically relevant to the requirements of this provision to prioritize need for guardianship, this issue does indicate one reason why an individual may need assistance or advocacy in decision-making—to ensure necessary services and supports are not delayed and that rights are not restricted beyond when the restrictions are needed. | |
| 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, | <u>Policies and Procedures related to obtaining LARs for individuals in need:</u><br>DADS Policy 019: and RG SOP 200 also provided guidance and protocol as to obtaining LARs for individuals who may need one. The Policy designated the Facility HRO to act as the Guardianship Coordinator. Specific duties of the Guardianship Coordinator include the following:<br>• Establishing a Guardianship Committee that meets regularly to discuss guardianship needs at the State Center;<br>• Working with the QDDP Coordinator and QDDPs to develop and maintain a prioritized guardianship list of individuals in need of a guardian; | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | 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. | • Providing information to the State Center's Parent/Family Association members regarding alternatives to guardianship and local guardianship programs and resources;<br>• Sharing appropriate information regarding individuals in need of a guardian with local guardianship programs as permitted by law;<br>• Soliciting information from local guardianship programs regarding community supports available to assist with guardianship fees, court costs, and other expenses; and,<br>• Organizing an annual guardianship in-service for individuals, families, staff and other interested parties to discuss guardianship, alternatives to guardianship, the benefits and disadvantages of guardianship, limitations to guardianship, types of guardianship, who can and cannot be a guardian, and other relevant topics.<br><br><u>Efforts to Obtain LARs:</u><br>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.<br><br>The Facility was making efforts to obtain LARs.<br>• 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 HRO reported that six families were in process of application at the time of the compliance visit. This process had been delayed by a change in the form required for application for guardianship; the form required additional information for a new Physician's Certification of Medical Examination that the HRO reported was in process of being obtained.<br>• The judge, along with the HRO, made a presentation to the RGSC-Parents' Association at their May 5, 2012 meeting to inform families of guardianship opportunities at no cost. Following the presentation, seven families requested assistance in applying for guardianship and two requested assistance in gaining co-guardians. The HRO reported that these will be addressed when the original six families complete the guardianship application process.<br>• The HRO provided a copy of a log of contacts for guardianship from 2/18/11 through 7/20/12. 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. Many of these notes involved contact with families working with the judge to apply for | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | guardianship.<br><br>Self-Advocacy<br>Policy: DADS implemented Policy 057 Self-Advocacy 5/30/12. This policy establishes the requirement for each facility to have a self-advocacy program, assigns coordination responsibility to the Human Rights Officer, establishes two self-advocacy groups that will each meet monthly, lists responsibilities of officers and focus of meetings, and identifies data to be collected and entered in a statewide database. RGSC SOP 200 09 localizes the DADS policy, essentially repeating it and providing a name for the groups ("The Advocates).<br><br>DADS Policy 057 Exhibit A Meeting Agenda Template provides a template for meeting agendas. The observed meeting did not follow this agenda closely, and meeting minutes did not reflect that it was followed. As the self-advocacy group evolves into greater leadership by the members, this simple agenda format could be useful in assisting individuals to take leadership roles in meetings.<br><br>Meeting observed and review of minutes: The Monitoring Team observed the meeting of The Advocates on 8/29/12. Thirty-three individuals (47 % of total Facility population) attended. This was a remarkable participation. However, it was in line with the regularly increasing attendance, which the HRO reported and minutes listed attendance that reached 31 individuals at the July 2012 meeting. The HRO had taken many steps to increase attendance, including changing the time, providing snacks, and giving many reminders to individuals and staff. The Monitoring Team has seen these same efforts at many facilities, but never with this level of success at increasing participation.<br><br>A large attendance would not be important if most participants were passive. At this meeting, the HRO began by asking the President to call the meeting to order and make brief opening remarks. After that, the HRO led the meeting. She had an organized agenda to provide training to participants about Right to Privacy, including visual aids to held individuals identify where there should be privacy and what it means. For example, she showed a slide of a bedroom and asked what room that is; several members said bed or bedroom. She then asked what everyone should do before entering "your bedroom." One individual said people were to knock, and the HRO followed by having people practice knocking. This continued with telephone, bathroom, medication room, and examination room. Individuals were able to identify all but the examination room; for that, the HRO asked who their physician was and told them only the physician and nurse should be in the room. The HRO then asked what individuals should do if they feel the right to privacy was violated; many individuals gave responses about who they could tell. This training covered a right, gave numerous opportunities to respond, and encouraged | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | and got participation from many people. Following this training, she also addressed the topic of identifying and reporting abuse. She asked questions and asked individuals for responses. Most attendees participated actively, either answering questions or showing both close attention to the HRO--smiling, laughing, and showing interest through other means, with very few people sitting passively. The Monitoring Team would like to commend the HRO for an extraordinary outcome, both in attendance and in attention and participation.<br><br>The Meeting Records (minutes) for meetings held since the last compliance visit suggest a similar practice occurred at each meeting. Each had a different primary topic for training individuals on a specific right, including how to report violations or concerns. Each record identified how a number of individuals answered or asked questions. Each record noted that a dietician discussed diets with individuals and assisted in providing the snacks.<br><br>The Facility did not present to the Monitoring Team or discuss consideration of identifying outcomes of these meetings, in terms of effect of the specific trainings provided or in fostering decision-making. Developing such outcomes may help the Facility focus efforts toward self-advocacy.<br><br>As this process and group evolve, it will be important to implement additional practices to involve members in leading the meetings, identifying actions they would like to take, and carrying out advocacy efforts. As noted below, the HRO was in process of procuring and coordinating an initial self-advocacy training session for individuals who reside at RGSC.<br><br>Self-advocacy training: The HRO provided information on a plan for self-advocacy training including 10 individuals residing at RGSC and 10 community volunteers who will learn to serve as advocates for individuals. This implements the requirement in DADS and Facility policy to conduct "an annual self-advocacy in-service for residents of" RGSC and will need to be supplemented by such training for LARs/family members and Facility staff. The Arc of Texas will provide this training. DADS State Office provided information to assist the HRO to initiate contact with Arc of Texas. After experiencing this training, the Facility should consider whether to request additional training and/or how to establish recurring or continuing self-advocacy training that can foster the abilities of individuals to participate in meaningful decision-making about their lives on an ongoing and formative basis. | |

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

1. The Facility must ensure the composition of the assigned Guardianship committee meets the requirements of Policy 019 for the Guardianship Committee. (Provision U1)
2. The actual responsibilities of the Guardianship Committee under DADS Policy 019: Guardianship should be clarified. (Provisions U1 and U2)
3. DADS should clarify how the two sets of criteria for prioritization found in DADS Policy 019: Guardianship are meant to be integrated. (Provision U1)
4. The Facility must develop a structured process to assess capacity to make decisions, train IDT members, and monitor to ensure capacity is considered as the IDT identifies need for assistance in decision-making and makes decisions on rights restrictions. DADS should provide guidance as to the standardized tools or processes IDTs should use to assess decision-making abilities so that guardianship does not extend beyond the areas needed by the person. (Provision U1)
5. The HRC review of informed consent for restrictions should be more effectively structured to help guide IDTs toward providing more training and support for individuals' decision-making capacities. Action Plans and SAPs should reflect such training and support. (Provision U1)
6. After experiencing the Arc training, the Facility should consider whether to request additional training and/or how to establish recurring or continuing self-advocacy training that can foster the abilities of individuals to participate in meaningful decision-making about their lives on an ongoing and formative basis.

| SECTION V: Recordkeeping and General Plan Implementation | |
|---|---|
| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. RGSC Self-assessment CV 5 dated 8/13/12<br>2. RGSC Action Plans CV 5 dated 8/9/12<br>3. RGSC Entrance Presentation handout<br>4. DADS Policy 020.1 Recordkeeping Practices 3/05/10<br>5. List of new or updated Facility policies since last compliance visit<br>6. RGSC SOP HIM400-02-ICF Additions, Updates and Changes to the Unified Record 6/20/12<br>7. RGSC SOP HIM 400-05 Record Control Log-ICF 6/18/12, active record check-out form, and training sign-in sheet for 8/2/12<br>8. RGSC SOP HIM 400-07-ICF Documentation Guidelines revised 7/17/12<br>9. RGSC SOP HIM 400 14-ICF Filing and Purging of Information Policy/Procedure revised 7/17/12<br>10. RGSC SOP HIM400-15-ICF ICF-DD Transcription of Clinical Assessments 7/17/12<br>11. RGSC SOP HIM 400-20-ICF ICF-DD Monthly Record Review 7/26/12<br>12. RGSC SOP ICF-IID 400-14 Medical Care July 2012<br>13. RGSC SOP QM 100-022 Rights Violations July 2012<br>14. RGSC Unified Record Training materials and sign-in sheets from 3/712-8/21/12<br>15. Tables of Contents for Active Record (Active Record Order and Guidelines-7/17/12 and 7/19/12), Individual Notebook (1/26/11), and Master Record (3/2/12)<br>16. Share Drive assessment folder for Individual #48<br>17. Active Record for Individual #145<br>18. Individual Notebooks for Individuals #4 and #19<br>19. Active Record audit forms for the last 11 audits conducted May through July 2012 for Individuals #1, #3, #15, #26, #33, #94, #118, #126, #132, #133, and #134<br>20. Inter-rater audit for Individual #126<br>21. List of audits scheduled for August 2012<br>22. Action/Corrective Action Reporting Document for issues identified in audits of records of Individuals #1, #3, #15, #26, #33, #94, #118, #126, #132, #133, and #134, and for completion of V4 Interview Tools<br>23. Email of 7/26/12 from Melissa Canales to QDDPs with Subject: Open CAPs reminding them of the need to provide assessments missing in active records; email noted attachment of open CAPS (not provided to Monitoring Team)<br>24. Email stream regarding open CAPs needed from a QDDP who had left RGSC<br>25. Training/Course Sign-In Sheet for training on Checking Out Active Client Records 7/18/12<br>26. New Employee Orientation RGSC Unified Record Training materials and Training/Course Sign-In Sheets<br>27. ICF Monthly Delinquent Assessment Report for June 2012, revised 7/18/12<br><br>**People Interviewed:** |

| | |
|---|---|
| | 1. Leticia Gonzalez, RHIT, Health Information Management (HIM) Director, and Melissa Canales, RHIT, Unified Records Coordinator<br>2. Mary Ramos, Quality Management Director, and Lorraine Hinrichs, ICF-IID Program Director, joint interview regarding policy development<br>3. QDDPs Rebecca Olivares, Karina Serratos, Melissa Martinez, and Robert Morales<br>4. Direct Support Professional (DSP) at La Paloma<br>**Meeting Attended/Observations:**<br>1. ISP annual planning meeting for Individual #141<br>2. Quarterly psychiatric medication review for Individual #3<br>3. Records storage areas at La Paloma, El Paisano, and vocational services |
| | **Facility Self-Assessment:**<br>The Facility provided a self-assessment and action plans. For the self-assessment, the Facility reported for each provision the activities engaged in to conduct the self-assessment, results of the self-assessment, and a self-rating with rationale for the rating. For each, some useful and appropriate activities provided information on status. Additional activities should be identified based on the information in the Assessment of Status below, as there were important issues not self-assessed. Some activities resulted in provision of data that reflected status. It would be useful for the Facility to use, to the greatest extent appropriate, or to establish quality assurance data so that the self-assessment could be integrated with the regular quality assurance activities of the Facility, as was done with audit compliance scores.<br><br>The Facility reported that none of the provisions of this Section were yet in compliance. The Monitoring Team concurs.<br><br>Most items in the Action Plans were described as "In Process"; many of those would always be ongoing, so it is important that the Facility identify specific descriptions of what is to be accomplished. For example, the very first action for Provision V1 is to create templates in existing assessments in CWS; this may continue to occur as changes are made in assessments and new assessments are developed. It would be useful for the Facility to plan which assessments are to have templates by when, and also to develop a process to determine when and how new templates will be developed (a process for which a SOP exists, but for which planning and prioritization could be an action step). Many of these "In Process" actions have already been implemented (and, in fact, are simply a restatement of Facility procedures), such as the monthly record audit and initiating CAPs for deficiencies, so the Action Plan should now build on those steps in a sequential way to ensure they result in improvements in actual performance that complies with requirements of the Settlement Agreement. |
| | **Summary of Monitor's Assessment:**<br>The Facility had continued to make progress toward compliance, in terms of maintaining a unified record, auditing the record for compliance, making use of the records, and developing or revising policies needed to implement the Settlement Agreement. Improvements remain to be made in all provisions.<br><br>The Unified Record contained all required components. Records were in generally good condition, were |

| | |
|---|---|
| | accessible and secure, included most documents, and were legible. Active records contained most required documents and few errors when compared to Appendix D requirements; however, some documents (including assessments but also other crucial documents such as the Integrated Risk Review Form and Rights Assessments) were not in the Active Record, or were not current. There was no evidence that the Facility was addressing systemically the consistent absence of assessments and other documents or addressing gaps between entries.<br><br>The Share Drive provided a means to make records readily available. As with the paper records, many assessments were not posted timely to the Share Drive.<br><br>Policies guiding recordkeeping had been revised to address more clearly some of the requirements of Appendix D and to clarify processes to make records accessible. Most Appendix D requirements were met, with the exception of completeness of the records (as noted above) and gaps between entries.<br><br>The Clinical Work Station (CWS) Integrated Progress Notes, which were organized chronologically by discipline, did not provide an easy way to tie clinical data together in a meaningful way to gain a clear and comprehensive picture of an individual's clinical status.<br><br>The Facility had a robust records audit system that audited five or more records monthly. Inter-rater reliability was assessed for one record audit each month. Results of these audits showed progress toward having accurate and complete records. Corrective actions were identified and assigned for deficiencies in individual records, but systemic issues were not being addressed with systemic actions.<br><br>Regarding use of the records for decision-making, the Facility had continued to use the statewide interview process to ask IDT members about their use of records. Observations by the Monitoring Team at IDT meetings indicated the Teams were not consistently using data to make decisions. Furthermore, audits showed that the quality of data and information in the records often was not adequate to allow teams to make well-informed decisions.<br><br>The Facility needs to also look more broadly at other ways to identify whether records are being used.<br><br>Both DADS and the Facility had continued to develop and revise policies but not all requirements of the Settlement Agreement have yet been addressed. The Facility needs to develop procedures to ensure staff are informed and understand newly developed and revised policies and that these policies are implemented accurately. |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| V1 | Commencing within six months of the Effective Date hereof and with full implementation within four | <u>Maintenance of a Unified Record for Each Individual</u><br>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 | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D. | Residential and Vocational), Master Record, Overflow (which remains in the Master Record until the retention period is completed), and the Clinical Work Station (CWS). The CWS, an electronic system, included progress notes, medical progress notes, and nutritional reports (not including PNM). 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.<br><br>The process for filing in and purging of records at RGSC differed from that at the other facilities reviewed by this Monitoring Team. At RGSC, all filing an purging was done by the Health Information Management department staff. 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.<br><br>Nearly all DADS policy requirements were covered in Facility policy. However, Facility policy 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.<br><br>Records were generally well-organized, and it was not difficult to find documents.<br><br><u>Policies Governing Recordkeeping</u><br>Several policies governed recordkeeping.<br>• 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. This policy was revised to add guidance on correcting errors, legibility, and using identification or job title, and to emphasize not leaving lines or spaces between entries.<br>• 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; this policy was revised to require identification or job title.<br>• 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. This policy was revised to add the process for inter-rater audits and to require corrective action plans for interview tools not completed and returned timely.<br>• Policy 400-02, which was initially a policy for the whole facility, was revised to | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | address specifically ICF requirements for the process to make additions, updates, or changes to the records.<br>• RGSC SOP HIM400-15-ICF provided a process for transcription of clinical assessments. This policy was revised to provide a process to notify each physician of notes pending review and revision or signature.<br><br><u>Accuracy and Completeness of Records</u><br>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 Active Record for Individual #145 (selected through computerized randomization from among the individuals who had been admitted since the last compliance visit) and the Individual Notebook for Individuals #19 (selected during observation of a living unit), as well as the last 11 audits conducted by the Facility in May, June, and July 2012 and included in the document request.<br><br>The Monitoring Team checked for the presence of each item on the Active Record Order & Maintenance Guidelines (AROG). To do this, the Monitoring Team used a tool used as part of the audits at the Facility called the Active Record Audit that had a place to check whether a document was present, not present, or not applicable to the individual. This tool also listed, for each tab or section of the Active Record, several requirements of Appendix D, such as whether "Documentation is current, complete, and in correct orde per guidelines." Many documents are not applicable in each record. The Monitoring Team made an effort through review of other documents in the record to determine whether such a document, if not in the record, was applicable. For example, if an individual had in the record an action plan with a specific learning goal, there would be an expectation that a matching Specific Program Objective would be in the appropriate section of the record.<br><br>For Individual #145, 42 documents were in the Active Record, 12 required documents were not in the Active Record, and 40 documents were not applicable. Therefore, 42 of 56 documents that should have been in the Active Record (75%) were found in it (a figure consistent with the 79% compliance rate reported by the Facility for June 2012 audits, as noted in Provision V3). Review of the Appendix D requirements found several issues:<br>• Due to missing documents, some sections of the Active Record were found not to have documentation current and complete. For example, in the Special Objectives tab, many Specific Program Objectives (training objectives, now called Skill Acquisition Programs) were to be completed by 8/3/12 for implementation but were not in the Active Record (the actual data sheets for the current month were to be in the Individual Notebook). | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • There were gaps between entries in the documents in the tabs for Labs, Psychiatry, and Physician's Orders.<br>• Documentation was not consistently authenticated with signature, job title and dated with month, day, and year for side effects screening, and the MAR did not have a legend for initials.<br><br>The Monitoring Team also reviewed the Individual Notebooks (All About Me books) for Individuals #4 and #19. Both books were complete and in good order, except that neither included the daily schedule that was required according to the Individual Notebook Table of Contents.<br><br>The Monitoring Team reviewed the last 11 completed audits from May through July 2012 provided prior to the compliance visit in response to the document request. All (100%) were found to have at least two missing documents; in many cases, these were noted as present but not current. Although this might be considered a positive finding, as few had extensive lists of missing documents, some of the documents were crucial. For example, eight (73%) did not have a current Rights Assessment, eight (73%) did not have a current Integrated Risk Rating Form, and three (27%) did not have an ISP in the record. However, the Facility had effectively addressed a concern noted in the last compliance report; at that time, the CLOIP document was routinely missing. Current audits documented that a current CLOIP document was in 9 of the 11 Active Records (82%); in the other two records, a CLOIP document was present but was out of date.<br><br>Most Appendix D requirements were reported as met. Of those that weren't, the most common was gaps between handwritten entries, which occurred in several tabs in nearly every Active Record.<br><br>Audits included Individual Notebooks. Eleven of 11 (100%) documented that all required documents were present. The only Appendix D requirement consistently unmet was gaps between entries.<br><br>As the Monitoring Team reviewed a large number of records, additional errors were noted. For example:<br>• As reported in Provision L2, the Facility had implemented a system for staff to enter individuals' daily bowel eliminations reports into CWS; binders in the Nursing Office had paper copies of a minority of these records, and nurses reported not knowing how to access those records in the CWS. When these were accessed, seven of 10 sampled (70%) had either no documentation for bowel elimination patterns or were recorded as zero for five or more days, indicating either lack of documentation or serious medical issues that were not being | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | identified from the records and addressed.<br>• Provision M1 noted demographic information printed on the forms using the addressograph cards and machines were not readable. Either the addressograph cards were worn-out or the machines were out of ink.<br><br><u>Clinical Work Station</u><br>Documentation in the CWS was, of course, legible and readable. The presence of two separate systems remained problematic. 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. Examples of problematic issues with the use of CWS included:<br>• As reported in Provision M1, there was no improvement in the Integrated Progress Notes contained in the Client Work Station (CWS), which continued to make it difficult to tie clinical data together in a meaningful way to gain a clear and comprehensive picture of individuals' clinical status. 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.<br>• As reported in Provision O2, The Clinical Work Station (CWS) Integrated Progress Notes (IPNs) was intended to be the primary location of progress notes but these were not utilized accordingly. PNMT meetings, mealtime observations, and assessments were not consistently referenced as part of the IPNs.<br><br><u>Accessibility and Security of Records</u><br>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. At the last compliance visit, 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; in response, the Facility revised SOP HIM-400-05-ICF to state that "No charts are to remain locked in staff offices, nurses stations or medication rooms when not in use." The Monitoring Team did not identify occurrence of individual records being kept in a locked room and not readily | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | accessible during this visit.<br><br>Observations of the records rooms in the living units verified that checkout forms were being completed, that Active Records were both secure and easily accessible to staff, and that Individual Records were kept in places where they were readily available when not with an individual but were not easily visible to individuals who should not have access. Observation at the vocational services area also found that Individual Records were accessible but not in the open for view.<br><br>When asked, a DSP at La Paloma showed where to find Individual #19's Individual Notebook, which was in a rack with others.<br><br><u>Use of Share Drive</u><br>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. The Monitoring Team asked the QDDPs to find assessments for an individual whose ISP annual planning meeting was to be held the week after the compliance visit. A QDDP easily navigated to the correct folder for Individual #48, identified which assessments were posted, and read them. Not all required reports were present, as reported in Provision F1c.<br><br>The Share Drive also contained an appointment schedule that QDDPs can review to identify who will need special supports or pre-treatment sedation, and to see whether appointments planned at an ISP meeting was made.<br><br><u>Conclusion</u><br>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 Integrated Risk Review Form and Rights Assessments or addressing gaps in documents. Most serious is the difficulty in ensuring all documentation to be done in CWS was being done, and that information from CWS could be accessed in a way that would make the information usable for 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 | <u>Facility Process to Develop and Revise Policies</u><br>Per interview with Mary Ramos and Lorraine Hinrichs, all policies are reviewed and updated annually. Each month, a different manual is reviewed and revised. The process for developing policy had not changed. A proposal for a new policy or a revision may come from a department, a committee, corrective action plan that may come through the | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement. | Settlement Agreement-Program Improvement Committee (SA-PIC), or any staff member. These come to the ICF-IID Program Director (for ICF policies), who drafts an update and sends it to the Quality Management Director and all department heads for comment, or to the Quality Management Director and all department heads (for facility-wide policies). After comments are received, the ICF-IID Program Director or another staff makes revisions as needed and takes the draft to the Professional Staff Organization (PSO) committee. Following PSO approval, the policy is placed in a folder on the Share Drive and is sent out to all people responsible for policy binders. 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.<br><br>The ICF-IID Director and Quality Management Director stated there had been no change in the process to notify staff of new and revised policies. The policy is sent to department heads and residential supervisors, who are responsible for training and submitting training rosters. For some policies, there is a test; completed tests would be attached to the training roster and placed in the individual employee's competency file. The person who generates the policy typically decides who needs training. The Facility did not have a process to ensure policies were disseminated and staff made aware of new policies or revisions unless training was provided. The Monitoring Team recommends that procedures be implemented to identify, during the policy approval process, who needs training and what sort of training must be completed, who will provide training, who has been trained, and how the Facility can ensure and document that staff are made aware of policies when no competency test is required.<br><br><u>New and Revised Policies</u><br>The Facility provided the Monitoring Team with the following policies revised since the last compliance visit:<br>• RGSC SOP HIM400-02-ICF Additions, Updates and Changes to the Unified Record 6/20/12<br>• RGSC SOP HIM 400-05 Record Control Log-ICF 6/18/12, active record check-out form, and training sign-in sheet for 8/2/12<br>• RGSC SOP HIM 400-07-ICF Documentation Guidelines revised 7/17/12<br>• RGSC SOP HIM 400 14-ICF Filing and Purging of Information Policy/Procedure revised 7/17/12<br>• RGSC SOP HIM400-15-ICF ICF-DD Transcription of Clinical Assessments 7/17/12<br>• RGSC SOP HIM 400-20-ICF ICF-DD Monthly Record Review 7/26/12<br>• RGSC SOP ICF-IID 400-14 Medical Care July 2012 | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | • RGSC SOP QM 100-022 Rights Violations July 2012<br>• RGSC SOP ICF-IID 400-14 Medical Care July 2012<br>• RGSC SOP ICF-IID 700 14 The Use of Restraint June 2012<br>• RGSC SOP ICF-IID 400-16 Premedication for Medical and Dental Procedures August 2012<br>• RGSC SOP ICF-IID 500-07 Use of Mechanical Devices to Prevent Involuntary Self Injury and to Provide Postural Support August 2012<br>• RGSC SOP QM 100.014 DADS Quality Assurance Expectations July 2012<br><br>Additional policies on rights violations and pharmacy procedures were provided to member of the Monitoring Team. Furthermore, the Self-Assessment listed policies that were not provided to the Monitoring Team, either in response to the document request or during the compliance visit. These included:<br>• Speech Recommendations / MD Orders (04/30/2012).<br>• Restraint Checklists (05/03/2012).<br>• PSP Addendum with Signatures (06/28/2012).<br>• Vital Signs documentation in CWS (06/2012)<br>• Speech Communication Comprehensive Assessment (07/12/2012).<br>• Annual Integrated Risk Rating Form (IRRF) (07/23/2012).<br><br>An example of changes in these policies included: The Facility had updated its Quality Assurance policy and its Improving Organizational Performance Program document. These updates were completed in July, 2012 and included revisions necessary to meet the requirements of the revised DADS QA policy which was issued in January, 2012. These updates also added to each document a description of the Facility's Corrective Action Plan (CAP) process.<br><br>DADS had also continued developing and revising policies. New and revised policies included the following:<br>• DADS Policy 054 Medical Peer Review 5/30/12<br>• DADS Policy 057 Self-Advocacy 5/30/12<br>• DADS Policy 001.1 Use of Restraint 4/10/12<br><br>In addition, DADS developed and implemented a new format and process for ISPs. Staff at RGSC had an initial training, and the first two ISP annual planning meetings using this process were held during the compliance visit. At the time of the compliance visit, this new format and process were supported by draft DADS Policy 004.1 Individual Support Plan Process, which did not yet have a implementation date. | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Areas in Which Efforts Are Needed<br>Although the Facility had developed or revised policies and had a process in place for annual review of policies, the Facility needs to establish more formal means to identify what aspects of policies require training, who needs training, who will provide the training, and who has received training. It would be useful to present findings related to training in terms of the number of staff that have successfully completed the training (n) over the number of staff that require the training (N) to show the percent compliance with completion of the training (n/N). Once policies are trained, the Facility needs to have processes in place to determine whether they are implemented accurately and whether corrective or improvement actions are needed.<br><br>DADS needs to continue to develop and revise policies to ensure all that are needed to implement Part II of the Settlement Agreement are in place. There should be a plan or concerted effort to finalize policies currently in draft form that are actually in process of implementation, including the ISP and restraint policies, as well as to complete others that remain in draft form or have not yet been developed.<br><br>Some additional DADS and Facility policies need to be developed. For example, as reported in Provision L4, there is a need for additional policies to guide medical care. As reported in Sections G and H, policies on integrated clinical care and on minimum elements of clinical care remains undeveloped or in draft form. | |
| V3 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence. | Audit Policy and Process<br>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.<br><br>Documentation of audits conducted in May through July 2012, along with the schedules of audits for August and September 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. While not a random audit, this system ensures every record will be audited annually. Although this process ensures that five records will be reviewed monthly and that all individuals' records will be reviewed annually, perusal of the audits indicated that some items found not current or in records might not be due until 30 days following an annual ISP planning meeting; the Facility should ensure consistency between policy timelines for completing reports or preparing postings and the definitions used in the audit process. | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | Audits were done on Active Records and on Individual Notebooks (Residential, Vocational, and Retirement when applicable). They included audit of progress note entries in CWS.<br><br>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. The audit forms had been revised since the last compliance visit to include documentation of legibility. 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. The staff auditing the record marked Yes, No, or NA for each item, whether it involved presence of a document or compliance with an Appendix D requirement. This format can provide information by section of the active record, which could help in providing information for systemic corrective actions.<br><br>As reported in interview with HIM staff, 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. Selection is not random but involves rotation across QDDPs. The interview form is sent out to the QDDP and to each of the IDT clinicians involved in documentation of care; a due date of 20 days later is given. HIM staff copy the responses and paste into one complete interview tool. From the information, they identify and share issues that have been noted. There is no process or practice for doing trend analysis.<br><br>Because HIM staff did filing and purging, they completed those actions immediately, as well as correcting problems with order of documents. Other issues identified from the audits as needing correction were placed on an Action/Corrective Action Reporting Document by HIM staff and assigned to an individual staff for action. A single reporting document could include several needed actions, such as providing several annual assessments that were missing (the most common action reported on these documents as needed). An improvement noted on these documents from those at the last compliance visit was that actions for each individual record are on a separate document, rather than having actions needed for more than one individual on the same document; this should make it easier to track and maintain information on corrective actions for specific records.<br><br>Given the number of audits that identified gaps between entries, it appears the HIM staff corrected those; this could be problematic, as HIM staff would not know whether additional document entries should have been made and may be missing, so it would be advisable at least to confirm those revisions with staff who make these entries. That | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | would also provide notice to those staff (and perhaps their supervisors if these are frequent errors) of the need to take greater care in completing the entries.<br><br>The reporting document had a place to identify type of evidence submitted and the date submitted. This was filled in for only one of the documents provided to the Monitoring Team, for Individual #1. An email from Melissa Canales to QDDPs on 7/26/12 provided a follow-up request for them to provide missing documents. For one QDDP who left RGSC, an email stream documented ongoing attempts to gather all required documents. Although it seemed clear that there was continuing follow-up of CAPs till resolution, it would be helpful if the Facility provided evidence of completion of corrections at the next visit.<br><br>Per interview with HIM staff, CAPs were individual and did not address systemic issues. A training sign-in sheet documented training was provided about the records check-out procedures; the HIM director reported this was in response to a concern identified from V4 Interview Tools about accessibility of Active Records, an issue not addressed on the audit tool.<br><br><u>Interobserver Agreement</u><br>For one record per month, a second HIM staff also audits the same record independently on the same day. The Facility provided the audit and the Interrater audit for Individual #126. Agreement was found to be 97% for Chart I, 100% for Chart II, 98% for Chart III, and 100% for the individual notebooks for residential and retirement. For items for which there was disagreement, the reliability observer wrote an explanation. There was no indication through interview or other means that the Facility gathered those explanations and revised instructions or definitions so there would be no drift in the definitions and new observers could have complete definitions. As discrepancies in audit findings between primary and reliability observers are identified through reliability checks, they should be used to refine definitions and instructions to reviewers.<br><br><u>Audit Findings</u><br>The Monitoring Team reviewed the last 11 completed audits from May through July 2012 provided prior to the compliance visit in response to the document request. All (100%) were found to have at least two missing documents; in many cases, these were noted as present but not current. Although this might be considered a positive finding, as few had extensive lists of missing documents, some of the documents were crucial. For example, eight (73%) did not have a current Rights Assessment, eight (73%) did not have a current Integrated Risk Rating Form, and three (27%) did not have an ISP in the record. However, the Facility had effectively addressed a concern noted in the last compliance report; at that time, the CLOIP document was routinely missing. Current audits documented that a current CLOIP document was in 9 of the 11 Active Records (82%); in | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | the other two records, a CLOIP document was present but was out of date. These data, along with the findings of the audit done by the Monitoring Team, would indicate the audit process finds errors but not that procedures to minimize recurrence were yet in place.<br><br>Although audits documented most Appendix D requirements were met, all (100%) documented gaps between entries in some sections of the record.<br><br><u>Review of Trends and Use of Audit Information for Improvement</u><br>The Facility provided the Monthly Delinquent Assessment Report for June 2012, revised 7/18/12. This report included a graph of monthly chart audit compliance scores from April 2011 through June 2012, a chart review compliance percentage by department graph from September 2011 through June 2012, and a "Summary of Findings: Assessments Falling out (under 90%) by discipline (Feb'12-Aug'12)" with graphs for QDDP and Nursing. For the reporting period of June 2012, the report state there were five total records reviewed, 330 total assessments reviewed, and 68 total assessments noncompliant for a compliance score of 79%, a decrease from data presented on the graph for the last 12 months. Although the total compliance scores over the past year indicated acceptable compliance, the number of assessments not being provided (as shown on the QDDP summary of findings) indicated a need for improvement. Other than CAPs on individual records, and the email documenting follow-up of assessments that were still missing after the due date for CAP completion, no evidence of systemic action to improve this was provided to the Monitoring Team.<br><br><u>Additional Audits</u><br>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.<br><br>The Facility also reported conducting an "Under Reporting Record Review" completed monthly by the URC, in which one individual is selected from each home using the list of records audited for the monthly record review. Such review included the nursing quarterly report, biophysical assessment, 24-hour ICF-DD care flow sheet, integrated progress notes, and injury reports in CWS. Refer to Provide D2f for further information about this process.<br><br><u>Summary</u><br>The audit process was robust and systematic, although the Facility could consider | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | reviewing the form to address whether records are either available or checked out (or to assess that in another way, because the practice of filing by HIM staff means that they can check that each time they file documents). Two issues need to be addressed more thoroughly. First, documentation should be entered onto the CAP form of whether the CAPs are completed by due date and, if not, of the immediate follow-up actions taken, so that follow-up action occurs (and is documented) regularly. Second, the Facility should identify when systemic actions should be taken, should plan and implement those actions, and should monitor and report evidence of the effectiveness of those actions. | |
| V4 | Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions. | The Monitors and the parties agreed to a list of actions that the facilities would engage in to demonstrate substantial compliance with this provision item. These actions are categorized below, with report of their status at RGSC.<br><br><u>Records are accessible to staff, clinicians, and others</u><br>The Facility was not yet assessing this. The Monitoring Team observed that records were available and easily accessible to staff providing services and supports. Individual Notebooks were found in the area in which individuals were, including living areas and day program sites. Active Records were kept in a secure area to which staff had access.<br><br>The S: Drive made assessments readily available to clinical staff, residential directors, QDDPs, and others who might need to refer to them.<br><br>However, the Monitoring Team observed that although records were accessible, they were not always used in delivering services and supports. For example:<br>• As reported in Provision L2, the Facility had implemented a system for staff to enter individuals' daily bowel eliminations reports into CWS; binders in the Nursing Office had paper copies of a minority of these records, and nurses reported not knowing how to access those records in the CWS. When these were accessed, seven of 10 sampled (70%) had either no documentation for bowel elimination patterns or were recorded as zero for five or more days, indicating either lack of documentation or serious medical issues that were not being identified from the records and addressed.<br>• There was no improvement in the Integrated Progress Notes contained in the Client Work Station (CWS), which continued to make it difficult to tie clinical data together in a meaningful way to gain a clear and comprehensive picture of individuals' clinical status. This posed a barrier when integrating clinical data into a useful manner. While completing record reviews on the Integrated Progress Notes 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 | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | other disciplines and gain a true clinical picture of individuals' care.<br><br>On a positive note, in an effort to ensure accessibility of certain documents that teams needed to develop ISPs and engage in related activities, the Share Drive contained documents such as assessments, which made them readily available to IDT members. Furthermore, audits reported that most documents other than assessments were found in the records.<br><br>Also, the Monitoring Team observed that Active Records and Individual Notebooks were accessible. Although (as reported in Provision V3 and below in this provision) there had been problems with documents not being found in the records area and not checked out, the Facility had addressed this issue, and the Monitoring Team did not identify unavailable records.<br><br><u>Documents are filed in the record timely and accurately</u><br>The Facility did not report assessing this as part of the Self-assessment. However, this was assessed as part of the monthly record audit and the "Annual Assessments Filed Within 10 Days" report; these reports could provide information for the Self-assessment. As reported in Provisions V3 and F1c, assessments were often not completed or not entered into the records timely. Therefore, IDT members could not review the findings and recommendations in preparation for the ISP planning meeting.<br><br><u>Staff surveyed/interviewed indicate how the unified record is used</u><br>The Self-assessment reported that an interview form was sent to seven disciplines and identified two issues noted in responses.<br>• "In response to question 3: "Do you find the documents that you need in the record?" 6 of 21 (29%) responses received noted, "Most of the time" "Most often..." or "Yes but in the wrong tab."<br><br>• In response to question 4: "Do you have feedback or suggestions for how the record could be more useable for you?" 4 of 21(19%) responses noted records are not available or checked out. 3 of 21 (14%) responses requested revisions to record order/structure. 1 of 21 (5%) responses noted improvement in the turnaround timeframe of results."<br><br>The Facility provided the interview form for Individual #1. This provided responses from only three disciplines. The Facility rated all three responses as indicating the record is used when making decisions. Two of the three responses indicated a document was available but may not have been filed in the record. Two of three indicated they | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | could find documents they need in the record. The question asking for an example in which a report from another discipline helped the clinician plan a treatment or intervention was marked "N/A" for all three responses; the Monitoring Team feels this is an important issue in identifying how the record is used, and believes this information should be provided. The Monitoring Team will look forward to reviewing a more representative sample of these interviews at the next compliance visit. It should be noted that the Facility was able to provide information about how these interviews led to a systemic action. As reported in Provision V3, training was provided about the records check-out procedures; the HIM director reported this was in response to a concern identified from V4 Interview Tools about accessibility of Active Records, an issue not addressed on the audit tool. Reviews of the interview tool responses indicated several that stated that records were not available. HIM provided training to department heads and supervisors in July and August and has made this a standard agenda item at Provision of Care meetings where all department heads meet monthly. No assessment had yet been done of the effect of the training, but HIM staff reported the audit tool had been updated to ask if a record is either available or checked out.<br><br>The Monitoring Team used the same questions to interview the QDDPs about use of the record. QDDPs stated they could always find documents, and that documents are filed timely (although this statement was inconsistent with the findings of the records audits regarding assessments). They were able to give an example of using a report from another discipline to plan a treatment or intervention.<br><br><u>Observation at meetings, including ISP meetings, indicates the unified record is used and data are reported rather than only clinical impressions</u><br>The Facility had not yet implemented a process for incorporating information regarding the use of records during relevant meetings into the database for Section V.4.<br><br>The Monitoring Team did note that Active Records were available and were referred to during IDT meetings observed, but that the records could be used more effectively. For example:<br>• During the quarterly psychiatric treatment review meeting for Individual #3, graphs of injury data were reviewed. The Active Record was present, and seizure data were looked up and reviewed. The MBSS consultation report in the Active Record was reviewed. For most other discussion, there was a lack of reference to data; instead, impressions were reported. The team should either provide data from the record or use the record to report data as questions arise.<br>• During the annual review for Individual #141, a list of injuries was presented, information on weight was provided, and the date of an ophthalmology consultation was available. Although the Active Record was present, there was | |

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | no other reference to the records, and much of the discussion involved impressions rather than data or other documented information.<br><br>Although progress was being made, the Facility remained out of compliance with this provision. Teams were not consistently using data to make decisions, and the quality of data and information in the records often was not adequate to allow teams to make well-informed decisions. | |

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

1. Procedures should be implemented to identify, during the policy approval process, who needs training and what sort of training must be completed, who will provide training, who has been trained, and how the Facility can ensure and document that staff are made aware of policies when no competency test is required. A centralized process should be developed at least for specific critical policies to ensure all relevant staff receive consistent training. (Provision V2)
2. As discrepancies in audit findings between primary and reliability observers are identified through reliability checks, they should be used to refine definitions and instructions to reviewers. (Provision V3)
3. Documentation should be entered onto the CAP form of whether the CAPs are completed by due date and, if not, of the immediate follow-up actions taken, so that follow-up action occurs (and is documented) regularly. (Provision V3)
4. The Facility should identify when systemic actions should be taken, should plan and implement those actions, and should monitor and report evidence of the effectiveness of those actions. (Provision V3)
5. Monitoring efforts for Section V.4 should be expanded to include a number of different methodologies, including, for example, observing meetings in which information from the records needs to be utilized (e.g., psychiatric reviews, ISP meetings, etc.), and reviewing documents such as medical consultations and IPNs to ensure that key information from the record has been considered. All of these indicators might not be reviewed by the Unified Records Coordinators, but might be distributed in other monitoring tools. (Section V.3 and Facility Self-Assessment)
6. Implement procedures to monitor and coach staff to use information in the records to make data-based decisions. (Provision V4)

# List of Acronyms

**Rio Grande State Center**

August 27-31, 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, Action Plan |
| APC | Admissions/Placement Coordinator |
| APL | Active Problem List |
| APRN | Advanced Practice Registered Nurse |
| APS | Adult Protective Services |
| AROG | Active Record Order & Guidelines |
| AS | Action Step(s) |
| AT | Assistive Technology |
| BCBA | Board Certified Behavior Analyst |
| BIR | Behavioral Incident Report |
| BMC | Behavior Management Committee |
| BMD | Bone Mineral Density |
| BP | Blood Pressure |
| BSP | Behavior Support Plan |
| BSRC | Behavior Support Review Committee |
| CAP | Corrective Action Plan |
| CBC | Criminal Background Check or Complete Blood Count |
| 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 |
| DSP | Dental Support Plan |
| DUE | Drug Utilization Evaluation |
| EC | Environmental Control |
| EEG | Electroencephalogram |
| EKG | Electrocardiogram |
| ER | Emergency Room |
| FA | Functional Analysis or Functional Assessment |
| FAST | Functional Assessment Screening Tool |
| FBA | Functional Behavior Analysis or Functional Behavior Assessment |
| FFAD | Face-to-Face Assessment/Debriefing |
| FSA | Functional Skills Assessment |
| FSPI | Facility Support Performance Indicator |
| FTE | Full Time Equivalent |
| FY | Fiscal Year |
| GERD | Gastroesophageal reflux disease |
| HCG | Health Care Guidelines |
| HCP | Health Care Plan |
| HIM | Health Information Management Department at Rio Grande State Center |
| 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 |
| ICM | Integrated Clinical Meeting |
| 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 |
| IRR | Integrated Risk Rating |
| ISP | Individual Support Plan |
| IT | Information Technology |
| i.v./IV | Intravenous |
| LA | Local Authority (formerly MRA) |
| LAR | Legally Authorized Representative |
| LVN | Licensed Vocational Nurse |
| MAR | Medication Administration Record |
| MAS | Motivational Assessment Scale |
| MBSS | Modified Barium Swallow Study |
| MD/M.D. | Medical Doctor |
| MOSES | Monitoring of Side Effects Scale |
| MP | Medication Plan |
| MR | Mental Retardation |
| MRA/MHMRA | Mental Retardation Authority/Mental Health and Mental Retardation Authority |
| MRI | Magnetic Resonance Imaging |
| MRSA | Methicillin-resistant Staphylococcus Aureus |
| MSP | Medical Support Plan |
| MVC | Medication Variance Committee |
| NA | Not Applicable |
| NANDA | North American Nursing Diagnosis Association |
| NCP | Nursing Care Plan |
| NDC | Non Direct Care/No Direct Contact |
| 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 |
| PBMC | Psychiatric and Behavior Management Clinic |
| PBSC | Positive Behavior Support Committee |
| PBSP | Positive Behavior Support Plan |
| PBST | Personal Behavior Support Team |
| PCD | Planned Completion Date |
| PCP | Primary Care Physician |
| PDB | Physically Disruptive Behavior |
| PDD | Pervasive Developmental Disorder |
| PDP | Personal Development Plan |
| PFA | Personal Focus Assessment |
| PFI | Personal Focus Interview |
| PIC | Performance Improvement Council |
| PMAB | Physical Management of Aggressive Behavior |
| PMOC | Psychiatric Medication Oversight Committee |
| PMR | Psychiatric Medication Review |
| PMT | Psychotropic Medication |
| PNA | Psychiatric Nursing Assistant |
| PNM | Physical and Nutritional Management |
| PNMC/PNMPC | Physical and Nutritional Management Coordinator/ Physical and Nutritional Management Plan Coordinator |
| PNMP | Physical and Nutritional Management Plan |
| PNMT | Physical and Nutritional Management Team |
| PO | By mouth, oral intake |
| POC | Plan of Correction |
| POI | Plan of Improvement |
| PRC | Polypharmacy Review Committee |
| PRN | Pro Re Nata (as needed) |
| PSA | Prostate Specific Antigen |
| PSO | Professional Staff Organization |
| PSP | Personal Support Plan |

| | |
|---|---|
| PSPA | Personal Support Plan Addendum |
| PST | Personal Support Team |
| PT | Physical Therapy/Physical Therapist |
| PTP | Psychiatric Treatment Plan |
| PTR | Psychiatric Treatment Review |
| QA | Quality Assurance |
| QDRR | Quarterly Drug Regimen Review |
| QE | Quality Enhancement |
| QI | Quality Improvement |
| QMR | Quarterly Medication Review |
| QMRP/QDDP | Qualified Mental Retardation Professional/Qualified Developmental Disabilities Professional |
| QPR | Quarterly Psychiatric Review |
| RAD | Reactive Attachment Disorder |
| RC | Restraint Checklist |
| 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 |
| SAN | Settlement Agreement for Nursing |
| SAP | Skill Acquisition Plan |
| 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 |
| SSO | Staff Service Objective/Specific Service Objective |
| STAT | Immediate |
| STD | Sexually Transmitted Disease |
| TB | Tuberculosis |
| TD | Tardive Dyskinesia |
| TIVA | Total Intravenous Anesthesia |
| TO | Training Objective |
| 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 |
| WBC/wbc | White blood cell |
| x/o | Rule out |