United States v. State of Texas

Monitoring Team Report

Rio Grande State Center
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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.
g) **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

As always, 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. They ensured the documents requested were available before, during, and after the visit. They coordinated arrangements for all the meetings and observations. Many other staff assisted in numerous ways.

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 63 individuals.

Facility Self-Assessment. RGSC continued to improve its process of assessing status of compliance. The self-assessment described the activities engaged in to assess status, results (in some cases including data on status of processes or on outcomes), and the self-rating and rationale for the rating. The Monitoring Team provides, in this report, many specific reviews of the self-assessments to assist the Facility to select appropriate activities and measures of status and to describe reasons for discrepancies in ratings between this report and the self-assessment. The Facility should consider how it might expand use of its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes.

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

Specific Findings

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

Restraints

Restraint use at the Facility occurred infrequently. This review included a 100% sample of crisis intervention and medical restraints. Although restraints were used infrequently, there were several issues regarding use or documentation that need improvement. The Facility reported no use of medical restraint for dental procedures and limited use for medical procedures; although this might be a positive finding, it could also limit the availability of dental services or, as is noted in Section Q of this report, result in use of more intrusive anesthesia.

- Positive Practices and Improvements Made
    - No individual was restrained more than three times in a rolling 30-day period. A total of six crisis intervention restraints were used for four separate individuals in the six months prior to the compliance visit.
    - Documentation was provided to verify restraints were consistently terminated as soon as the individual was no longer a danger to him/herself or others.
- Improvements Needed
    - Although restraints were used infrequently, review conducted by the Psychology Department identified several instances where restraint was used inappropriately and without clinical justification. It is positive, though, that the Psychology Department reviews identified these events, and that action was taken.

- The accuracy and completeness of restraint related documentation had deteriorated significantly from that observed at the last review.
- Direct care staff knowledge of basic restraint policy was lacking.

Abuse, Neglect and Incident Management

During this review, the Monitoring Team found the Facility to be in compliance with 21 out of 22 provisions of Section D, as opposed to 15 provisions that were in compliance during the last review. Progress was noted in a number of areas, including the one provision that remained not in compliance.

- Positive Practices and Improvements Made
  - The internal management and monitoring systems in place at RGSC were self-identifying instances of noncompliance with policy and procedure, especially in areas where clear data parameters exist such as the timeframes associated with reporting, with initiating investigations, and with completing investigations. These issues were immediately addressed when identified.
  - The IMRT process was in place and functions as a review body, meets daily, and its minutes reflects review of injuries, incidents, and investigation reports.
  - 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.
  - 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.
  - Staff training requirements were current. The Facility had an ongoing system for on-the-spot competency testing to ensure staff retains the key requirements of abuse/neglect training. This process needs improvement as the Monitoring Team met with 12 Direct Support Professionals (DSPs) whose knowledge of some of the basic principles associated with abuse and neglect reporting was disappointing.
  - Self-advocate meetings were held monthly and were well attended. Abuse and neglect reporting was reviewed at each meeting as a means of providing ongoing education to individuals.
  - All allegations of physical abuse were appropriately referred to law enforcement.
  - The DFPS Investigator interviewed expressed a high level of cooperation between Facility administrative staff and themselves. The Facility had made office space available to DFPS, and DFPS had an investigator working out of this office on a regular basis. This facilitates timely 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.
  - Presentation of information in UIRs was well organized in a manner that ensured all the requirements of the SA can be readily identified to determine compliance.

- Facility review of investigations ensured that the investigations were thorough and complete and that reports were accurate, complete and coherent.
- 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.
- Tracking and trending data was complete and regularly analyzed.
- Employee background checks occurred as required by State policy.

- Improvements Needed
  - 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. Still lacking at the Facility was a process which reviewed data associated with frequently injured individuals to assess whether or not the nature of the injuries, the time and/or place of the injuries, or any other factors suggested a need to examine trend data further to assess system causes and trends of injuries to prevent future injuries from occurring.

<u>Quality Assurance</u>

The Facility had done a number of things since the last review to move closer to compliance with Section E, including 1) updating its Quality Assurance policy and its Improving Organizational Performance Program document, 2) implementing Corrective Action Plan (CAP) initiation audits, CAP completion audits, and CAP effectiveness audits, and 3) taking action through a CAP reduction initiative to better define circumstances where a CAP is an appropriate mechanism for corrective action planning. On the other hand the implementation of QA processes at the Facility was variable department to department and the Facility needed to develop key indicators from which both processes and outcomes can be measured.

- Positive Practices and Improvements Made
  - The Facility collected data that was tracked and trended for most provisions of the Settlement Agreement. The Facility had laid a sound foundation for continued refinement of data tracking.
  - The data system developed by the Facility is extremely flexible and is being used more for management oversight and performance accountability.
  - The Facility put in place a system to identify the need for a CAP, track CAP assignments and completion status, periodically reviewing CAP status, and requiring evidence to substantiate CAP completion. Further, initiating CAP Initiation Audits, CAP Completion Audits, and CAP Effectiveness Audits are positive steps.
- Improvements Needed.
  - Data collection, reporting, and trending were not consistent in all areas of the ICF-ID program.
  - The Facility generates a large number of CAPs directed at administrative errors/omissions by individual staff, with the unintended consequence of an overwhelming amount of data. The Facility was engaging in a CAP Reduction Initiative to better define circumstances where a CAP is an appropriate mechanism for corrective action planning.

- 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 majority of CAPs (including those designated as high urgency) were not completed timely.
- Still lacking in the Facility QA process are elements intended to address substantive information regarding clinical outcomes and key indicators.
- 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. There remains a need to present data in more finite detail, for example, 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 where appropriate.

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

RGSC had just recently received training and initiated the revised ISP process. Certain steps in the process, such as the pre-ISP meeting, are just being initiated. Nevertheless, the Facility continues to make progress in a number of areas, although it has not achieved substantial compliance yet for any provision.

- Positive Practices and Improvements Made
  - The interdisciplinary teams are facilitated by QDDPs who have completed competency-based training.
  - Living Options Discussions at the ISP annual planning meetings observed were substantive.
  - The observed ISP annual planning meetings and the ISP Planning meeting demonstrated interdisciplinary and integrated discussion.
- Improvements Needed
  - Assessments must be completed timely so that information can be used consistently in decision-making.
  - Several disciplines had participated regularly in ISP annual planning meetings, but for others, participation was not consistent. Clear listings of which disciplines are required to participate will provide guidance, but the decisions on who is required should be made based on the preferences and needs of the individuals, not on what practice is routine or on the availability of resources.
  - Due in part to the lack of completed assessment, there was no evidence that the Facility had improved in identifying the supports, services, and protections that would be needed in a more integrated setting or in focusing more on the services and supports that would be needed for community living when developing action plans and goals.
  - ISPs did not provide adequate strategies to encourage meaningful community participation.
  - Although discussion at ISP annual planning meetings was integrated, there was little evidence in the ISPs themselves that such a unified approach was in place.
  - ISP revisions must be completed timely.

Integrated Clinical Services

The Facility had continued to progress toward providing clinical services in an integrated manner. Improvements had occurred through the Morning Medical Debriefing process, other committees and workgroups, and, to a degree, the ISP process. Continued implementation and improvement of the process of reviewing consultations had also occurred.

- Positive Practices and Improvements Made
  - Integrated discussions continued to provide opportunities for such integration to occur, and integrated discussion was evident in observed meetings if not in the documentation of services and supports.
  - The Facility had established policy and practices that address the requirements for Facility clinicians to review recommendations from consultants.
  - Facility clinicians documented review of recommendations by consultants and acceptance of consultant reports; progress notes were thorough and demonstrated follow up.
- Improvements Needed
  - Although the Facility had established several processes for integration of clinical services, there was still need for improvement in the actual integration of services.
  - Reporting at the morning medical meeting provided opportunity to inform clinicians from all disciplines and to ensure referrals are made to the IDT as needed. However, the Facility did not document that these referrals to the IDT were occurring.

Minimum Common Elements of Clinical Care

There had been modest continuing 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. Unfortunately, this finding is identical to that found in the report from the last compliance visit. The Facility should take more assertive action to meet the requirements of this Section.

- Positive Practices and Improvements Made
  - Diagnoses were consistent with the current versions of the DSM and ICD classification systems, and were generally consistent with the supporting assessments. However, it will be important for the Facility to review this report and the last one to identify areas in which more precise diagnosis (such as type of seizure) should be provided.
  - The Facility had made some progress on establishing processes to monitor the health status of individuals. One example was the continuing evolution of the Morning Medical Debriefing
- 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.

- 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.
- The Facility had done some limited expansion of development and use of systemic clinical indicators of efficacy of treatments and interventions in health care and other clinical areas. This remained in early stages and requires further development, both of a broader range of clinical indicators and of use of those in assessing status and planning improvements.
- 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.

<u>At-Risk Individuals</u>
In its last report the Monitoring Team noted limited improvement from that previously observed. This continued to be the case.

- Positive Practices and Improvements Made
  - Interdisciplinary assessments were generally comprehensive.
- Improvements Needed
  - 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.
  - ISP annual planning meetings continue to need improvement ISP regarding risk review, use of clinical data, 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.
  - The Facility had not updated its At-Risk policy (ICF-IID 400 02) to include revisions associated with the most recent revisions to State policy. The Facility had not conducted a comparative review between its general At-Risk policy and the at-risk policy in the Nursing Manual to ensure consistency between the two policies.

<u>Psychiatric Care and Services</u>
The Facility has continued to make progress in most provisions of Section J.

- Positive Practices and Improvements Made

- The Monitoring Team was impressed with the Facility's initial development and implementation of a polypharmacy committee, and with the comprehensiveness of the new psychiatric assessment process, that ensures a multidisciplinary, comprehensive assessment of individuals who are prescribed a psychotropic medication.
- The Facility had qualified professionals for the provision of psychiatric services.
- The treating psychiatrist conducted comprehensive review of the clinical data.
- The psychiatrist incorporated reasonable behavior data when developing a treatment plan, developed a reasonable bio-psycho-social clinical hypothesis, utilized DSM criteria when developing a psychiatric diagnosis.
- The Facility conducted psychiatric assessment in accordance with Appendix B of the Settlement Agreement for all new admissions, and performed a Reiss screen on all individuals referred to the psychiatrist for psychiatric assessment.
- The Monitoring Team compliments the Facility on its initial development of the polypharmacy committee. It was clear to the Monitoring Team that the level of professional involvement and review of individual cases was exemplary.
- The Facility completes side effect monitoring for individuals who are provided neuroleptics routinely, and when clinically necessary

- Improvements Needed
  - It remained unclear that behavioral programs were of adequate quality to ensure psychotropic medications were not used as a substitute for a treatment program.
  - A process to help reduce or mitigate the use of pre-treatment sedation for all individuals who are routinely provided pre-treatment sedation for clinical services did not exist at the Facility.
  - Although behavioral data were incorporated into the psychiatric assessments; meetings and psychiatric documentation provided evidence to support meaningful collaboration among the psychiatrist and psychologist in developing treatment plans, psychological and behavioral assessments and PBSPs did not provide evidence of combined assessment and case formulation.
  - The Facility must ensure, and provide evidence, that before initiating a new psychotropic medication, the IDT conducted a review, and that the psychologist, psychiatrist, nurse, and primary care physician discussed the risks and benefits of starting the new drug, and if reasonable alternative strategies would be beneficial.
  - The Facility must develop and implement a new consent process.
  - The Facility must have a process to ensure collaboration between the psychiatrist and neurologist when medications were prescribed to treat both a neurological and psychiatric condition.

<u>Psychological services</u>
RGSC had made progress in several areas but had not sufficiently addressed many areas needed for compliance.

- Positive Practices and Improvements Made

- The Facility had established and maintained an internal peer review process that reflected several essential components and procedures.
- In several records, data presentation and treatment monitoring reflected evidence-based practices.
- Several PBSPs reflected behavior analytic practices and were of sufficient quality to make behavior change likely.
- Data graphs, other than in relation to interobserver agreement (IOA), were sophisticated and useful.

- Improvements Needed
  - The Facility had not maintained efforts to measure and track IOA and treatment integrity procedures.
  - Psychological Assessment reports were not provided upon admission. Additionally, not all individuals were provided with Psychological Assessments annually or as often as needed.
  - The Facility often made use of parallel tracking mechanisms that did not reflect agreement. For example, the Facility had at least two systems for tracking the completion of Psychological Evaluations; the separate systems did not reflect agreement regarding Psychological Evaluations.
  - SFAs did not fully reflect the findings of psychiatric evaluations and did not adequately addresses behavioral components of mental illness.

<u>Medical Care</u>

The Monitoring Team noted significant improvement in many areas of medical services.

- Positive Practices and Improvements Made
  - Individuals were evaluated by the physician more timely then noted at prior Monitoring Team reviews, and the documentation of follow-up was more comprehensive; diagnoses were updated promptly.
  - The Facility was able to retrieve updated diagnoses efficiently, by means of an electronic database.
  - Follow-up on fractures, malignancy, and many other clinical conditions were noted to be greatly improved.
  - The physician documented the IPNs and annual medical assessments timely and comprehensively.
  - The Facility maintained a more comprehensive medical consultation scheduling process, and better ensured that individuals were followed-up regularly by necessary external medical consultants.
  - The medical examination room and equipment were determined to be excellent, and enabled the physician to complete comprehensive examinations.
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- Improvements Needed
  - The Facility must ensure more robust participation by primary care specialists in the IDT process. Follow-up on chronic care issues must be more regular.
  - There remains a need to enhance continuity of care for individuals who are hospitalized.
  - Follow-up and documentation must be done through full resolution of all clinically relevant acute care conditions.

- Develop and implement a medical quality assurance process, and ensure that there are policies, procedures, and/or guidelines for all system related clinical processes.
- Enhance the medical audit process by ensuring that medical management elements are developed for the most common, and most serious medical conditions that occur in people with intellectual disability.

Nursing Care

In general, some appreciable progress had been made in improving the integration of the Morning Medical Meetings and improving and expanding the Clinic Appointment Database. The Emergency Response system and Infection Control Program had maintained the positive practices found in the previous compliance review. However, the Nursing Department's ability to move forward toward compliance with provision related to nursing assessments and documentation appeared to have been hampered by the significant turnover in nursing administrative and management staff.

- Positive Practices and Improvements Made
  - Facility continued to conduct and to expand the integrated participation of staff attending meetings such as the Medical Morning meeting.
  - The clinic clerk had done an outstanding job improving and expanding a robust Appointment and Tracking Database to not only schedule clinic and consult appointments and to reschedule missed appointments, but also to capture and retain individuals' historical data regarding dates and types of past appointments/consults.
  - The Facility continued to comply with the Emergency Response Policy.
  - The Infection Control Preventionist continued to maintain an excellent Infection Control Program, with the exception of following-up on the Acute Care Plans developed and implemented by the nursing staff for "real time" reported infections to ensure they included all relevant preventive measures for the identified infectious/communicable diseases.
  - The Medication Workgroup Committee and Pharmacy and Therapeutics Committee met regularly as scheduled.
- Improvements Needed
  - The Nursing Department needs continued improvement to ensure that all Nursing Monitoring Tools and other audits are completed timely, accurately and according to the schedule, and then turned in timely to the Quality Enhancement Department. The Facility needs to enhance the inter-rater reliability process between monitoring/audits completed by the Nursing Department and the Quality Enhancement Nurse.
  - The Nurse Educator needs to develop a centralized system for tracking all nursing training. There is a continuing need to reinforce training on the nursing assessments and documentations, as well as on the nursing protocol cards.
  - The Medication Workgroup Committee and Pharmacy and Therapeutics Committee need to conduct a more in depth review of medication variances and ensure that local as well as systemic corrective actions are taken to mitigate medication variances.

- There was a continued need to enhance Medication Administration Observations, Medication Room Audit, and Medication Administration Record Audits. All medication variances committed by the responsible disciplines must be reported and corrective action provided when necessary. The Facility must ensure that all medication variances are reported.

Pharmacy Services and Safe Medication Practices

The Monitoring Team noted improvement in pharmacy services. The Facility had enhanced its QDRR process, developed a polypharmacy committee and medication management workgroup, improved data collection on medication variances, and is ensuring physician review and follow-up on pharmacy recommendations.

- Positive Practices and Improvements Made
  - The pharmacy department had documented an appropriate review of new medication orders, and ensured that necessary diagnostics were obtained when needed.
  - Significant improvement with the comprehensiveness of pharmacy completion of the QDRRs, and review and follow-up by physicians.
  - Reporting of single patient drug interventions included precise documentation of the issue, ensured that the prescribing physician was notified of the issue, and followed up through resolution, ensuring that the issue was appropriately managed. The Monitoring Team noted that the prescribing physician appropriately managed recommendations made through the QDRR process.
  - Monitoring of side effects for people prescribed neuroleptic medication was enhanced. MOSES and DISCUS assessments were completed routinely, and assessment forms were reviewed and signed by the prescriber within seven days from the date of the assessment.
  - A new workgroup, called the medication management workgroup, has been meeting monthly and is focusing on developing the infrastructure for the Facility's medication variance process. Medication variance data was being collected, and categorized on a monthly basis.
- Improvements Needed
  - There was a significant delay in many cases between when the medication was ordered, and when the script was reviewed by the pharmacists. For this reason, the Monitoring Team determined that the Facility was not in compliance with Provision N.1, and must enhance its process by ensuring a prompt review of all new medication orders.
  - QDRR summaries should be organized in a standard manner; the pharmacist should document all relevant components of the QDRR in sections.
  - The pharmacy was significantly behind with completing QDRRs timely.
  - The Facility must develop and implement a robust adverse drug reaction process.
  - The Drug Utilization Evaluation process must be enhanced.

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 Physical and Nutritional Support Plans (PNMPs) as they were noted be more comprehensive in addressing all areas in which physical and nutritional risk may be increased. The PNMT met regularly and improved its processes.

- Positive Practices and Improvements Made
  - The PNMT met regularly, which was positive, and 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 had shown improvement.
  - Improvement was evident with the Physical and Nutritional Support Plans (PNMPs) as they were noted be more comprehensive in addressing all areas in which physical and nutritional risk may be increased. Nevertheless, they need to become more comprehensive, as they lacked detailed information regarding oral care and dental.
- Improvements Needed
  - Need remained for development of a comprehensive PNM policy.
  - Consistency of attendance of PNMT members needs to improve, especially for Occupational Therapy.
  - RGSC continues to have difficulty identifying those individuals who are at risk and assigning the appropriate risk classification as it relates to issues related to PNM.
  - Integration of the PNMT recommendations into the ISP was not consistent and needs to improve.
  - Staff was observed not implementing PNMPs or displaying safe practices that minimize the risk of PNM decline.
  - 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 there was evidence of staff training, there was no clear method to determine if staff had received training prior to working with individuals.
  - The monitoring system, while more formal, remained unclear regarding the criteria in which individuals received certain levels of monitoring.
  - Processes regarding plans to return to oral eating were not yet developed, nor were clinical assessment data for individuals' potential to return to oral eating provided.

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. Improvement with the OT/PT policy needs to occur so that it clearly provides the detail needed to ensure consistent supports are in place and the team responds to changes in status in a timely manner. 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.
  - Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. Other than the limited evidence of restorative care, the primary support provided was via the PNMPs.
  - Therapy services were not consistently integrated into the ISP. There was little justification as to why it was felt that the individuals would benefit from many of the OT/PT programs.
  - OT/PT programs need clear measurable objective to determine efficacy of treatment.
  - The Facility was unable to provide information regarding the number of staff who were expected and who had completed annual refresher trainings related to Physical and Nutritional Supports; therefore. the Monitoring Team was unable to determine if staff were adequately maintaining their level of training and education.
  - Documentation did not permit the Monitoring Team to if repair of adaptive equipment was completed timely.

<u>Dental Services</u>

The Facility did not maintain a dental office; therefore, oral health care assessments and treatments were provided by community dentists, or at the local hospital. The Facility is, however, responsible to ensure that all necessary treatments, evaluations, and oral hygiene are provided as clinically needed, and per standard of care practice. The Monitoring Team noted little meaningful progress since the last reporting period, and strongly encourages the Facility to assertively address Provisions Q.1, and Q.2, of the Settlement Agreement.

- Positive Practices and Improvements Made
  - The Facility provided adequate oral hygiene. The Facility must update its policy on oral health care, to reflect the Facility's current practice.
- Improvements Needed
  - Annual dental evaluations were not completed timely
  - There was no formal process to assess individuals who experience a functional change that would result in the need for suction toothbrushing, and there was no formal mechanism to assess the efficacy of suction toothbrushing program
  - There was no policy or procedure for dental emergencies.

- The Facility must develop and implement a quality assurance process to assess the efficacy, and potential adverse outcomes, for dental services.
- The Facility needs to and implement a clinically sound approach to providing sedation for dental treatments.
- The frequency of implementation of dental rehearsal program must be enhanced.
- To ensure each individual receives planned care, the Facility should improve on tracking and trending system issues related to missed dental appointments.

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. A number of concerns remained. While there was some improvement noted for collaboration of Speech Services and Psychology, there still needed to be more collaboration with behavior supports so that there was a cohesive approach to addressing behaviors that had communication as a primary component. Other concerns focused primarily on the Facility's inability to complete assessments in a timely manner and provide detailed monitoring that clearly demonstrated progress and the functional intent of the programs.

- Positive Practices and Improvements Made
  - The number of shared Alternative and Augmentative communication (AAC) devices continued to increase.
- Improvements Needed
  - RGSC did not have a comprehensive communication procedure/policy that addressed all components of a functioning system.
  - Staff reported that due to responsibilities and expectations, they did not have time to address all of the individuals' needs in a timely manner.
  - Assessments were not completed in a timely manner and the communication assessments did not consistently include the manner in which strategies, interventions, and programs should be utilized throughout the day.
  - There was limited monitoring of communication devices

Habilitation, Training, Education, and Skill Acquisition Programs

It was not apparent that the Facility had the necessary systems or procedures in place to satisfy the requirements of the Settlement Agreement. Especially troubling were indications that the Facility did not recognize when problems existed in assessments, SAPs, or teaching efforts. The Facility did demonstrate progress in some discrete areas.

- Positive Practices and Improvements Made
  - Communication SAPs reflected relatively greater compliance with expectations than other SAPs.
  - The Facility had maintained acceptable levels of engagement and active treatment in some settings.

- Improvements Needed
    - A substantial portion of skill assessments were either submitted late or not at all, substantially limiting the ISP process.
    - Skill acquisition programs continued to reflect a lack of attention to accepted teaching practices and were unlikely to strengthen skills.
    - The performance of the IDT did not reflect familiarity with or application of evidence-based practices. In some circumstances, the IDT had approved SAPs that were based upon procedures that research had not demonstrated were effective or appropriate.

Most Integrated Setting

Since the baseline review, RGSC had done an admirable job of changing its whole approach to movement of individuals to more integrated settings. The number of people who moved was remarkable for a facility of this size. Careful planning had permitted successful moves of individuals whose needs were challenging. Continuing improvement in this planning, and greater consistency of this planning across individuals, would make compliance with the requirements of this Section achievable.

- Positive Practices and Improvements Made
    - A significant percentage of individuals moved to more integrated settings, and referrals continue. At the same time, observation of ISP planning meetings indicated careful decision-making about the appropriateness of referrals.
    - Outcomes of transitions were generally good.
    - Post-move monitoring visits were timely.
- Improvements Needed
    - The Facility should carefully review any adverse outcomes to identify means to improve transition and follow-up services or to identify what additional supports the State needs to ensure are in place.
    - Professionals must assess and make determinations of the appropriateness of movement to more integrated settings and the supports that would be needed for successful transition.
    - IDTs need to improve greatly their ability to identify protections, supports, and services individuals need in order to progress toward movement to more integrated settings and to succeed in those settings.
    - IDTs must identify, and ISPs must document, obstacles to movement to more integrated settings. IDTs must ensure that any supports identified as obstacles must actually not be available in preferred settings. IDT must improve in identifying a broader range of individualized actions to overcome obstacles.
    - Although the Facility provides numerous opportunities for education about community living, it should provide individualized plans and document these in ISPs. IDTs continued to need additional instruction as to how to develop an individualized education/awareness strategy for each individual that takes in to account their specific learning needs.

- The Facility did not consistently list in CLDPs the supports that each individual needs. CLDPs should more clearly identify the evidence that will be needed to show that supports are in place, and the evidence selected should, if present, substantiate the supports are in place.
- Transition assessments provided to the Monitoring Team were timely, but the Facility needs to ensure that all required assessments are completed.
- Documentation of the visits did not include all required information; for example, documentation did not state the day program sites visited in all cases, and little to no narrative was provided. However, the post-move monitoring visit observed by the Monitoring Team was comprehensive and thorough.

Consent

The HRO at the time of the last compliance visit had left the Facility, and there was a brief gap until a new HRO began. The new HRO has continued the initiatives implemented by the prior HRO. The Facility updated the guardianship priority list and continued its active self-advocacy program. The Facility documented 63% of individuals as being in need of guardianship.

- Positive Practices and Improvements Made
  - The Facility maintained, and updated 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.
  - The Facility maintained an active self-advocacy program including training on self-advocacy and rights; this had been improved by beginning to support individuals in taking leadership at meetings. In addition, the Facility had worked with Arc to present training sessions on self-advocacy to individuals residing at RGSC and to community advocates.
- Improvements Needed
  - DADS policy provided some guidance to the Facility in the development and maintenance of a prioritized list of individuals needing guardianship, but 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 or needs assistance to make such decision. Neither addressed standardized tools or methodology IDT should use to assess capacity to make decisions as part of prioritizing the need for an LAR, advocate, or other assistance an individual might need in decision-making.
  - The Facility had assigned the role of Guardianship Committee to an existing committee. The Facility should ensure the membership of this committee matches the requirements of statewide policy.

Recordkeeping and General Plan Implementation

The Facility continued to make progress in all areas of this Section. A unified record was maintained, and use of information from the records was improving. There was continued development of policies needed to meet the requirements of the Settlement Agreement.

- Positive Practices and Improvements Made
  - The Facility maintained a Unified Record for each individual.
  - Active Records, Individual Notebooks ("Me Books"), and the Master Record were both accessible and secure.
  - Training on documentation was provided both in new employee orientation and in refresher training.
  - The Facility had a robust audit system in place that audited all records annually (and a minimum of five per month), identified items requiring correction, tracked corrections and provided reminders until completion, and ensured items that were reported as completed actually had been completed.
  -
- Improvements Needed
  - Review of records by the Monitoring Team and data provided by the Facility found inconsistency in completeness of the Active Record and Individual Notebook. The major issue of lack of complete records involved late assessments.
  - Although the audit system was robust, two areas of improvement are needed. First, attention must be paid to items from audits of individual records that remain in need of completion for extended times. Second, the Facility should identify issues needing systemic improvement and implement effective actions.
  - Although many statewide and facility protocols and procedures required to implement the Settlement Agreement have been revised as needed, some essential protocols and procedures remain to be developed and implemented.
  - 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. 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.

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:** **Documents Reviewed:** 1. RGSC Self-Assessment 4/29/13 2. RGSC Action Plan 4/25/13 3. RGSC Section C Presentation Book 4. DADS Policy 001.1 Use of Restraint (4/10/12) 5. RGSC SOP ICF-IID 700-14 The Use of Restraint (7/12) 6. RGSC SOP NR400-20 The Use of Restraint (5/13) 7. RGSC SOP ICF-IID 200-02 Restrictive Practices (7/12) 8. RGSC SOP ICF-IID 400-16 Premedication for Medical and Dental Procedures (8/12) 9. RGSC SOP ICF-IID 500-07 Use of Mechanical Devices to Prevent Involuntary Self Injury and to Provide Postural Support (8/12) 10. RGSC SOP NR 400-25 Pre-treatment and Post-sedation Monitoring (5/13) 11. Crisis Intervention Restraint Log October 2012 through March 2013 12. Medical Restraint Log 8/21/12 to 2/24/13 13. Restraint Trend Report 4/30/13 14. Settlement Agreement Program Improvement Council (SA-PIC) minutes (7/31/12 through 3/14/13) 15. Training records for sample of restraint monitors 15. Restraint and Seclusion Workgroup meeting minutes 7/7/13 17. Sample C.1 Crisis Intervention Restraints (physical) - this was a 100% sample that included all seven restraints in the prior six months. Documentation provided included the restraint checklist; face-to-face assessment/debriefing forms; physician restrictions, if any; documentation of any changes to the Individuals Individual Support Plan (ISP), Positive Behavior Support Plan (PBSP), or Crisis Intervention Plan, if any: and, documentation associated with the Facility's restraint review processes. 18. Sample C.2 Staff Training Records for a selected sample of 25 staff, including the signed forms to show that each identified staff member had acknowledged his/her responsibility to report abuse/neglect. 19. Sample C.3 Medical Restraints - this was a 100% sample that included all four restraints in the prior six months. Documentation provided included the physicians' orders for the restraint including the monitoring schedule; the medical restraint plan; the restraint checklist; the documentation of the monitoring that occurred; any reviews of this use of restraint; and any applicable plan of treatments or strategies to minimize or eliminate the need for restraint. 20. Sample C.4 Crisis Intervention Restraints (chemical) - this was a 100% sample that included all three restraints in the prior six months. Documentation provided included the restraint checklist; face-to-face/debriefing form; any reviews of the use of this restraint; and evidence of contact between the psychologist and physician prior to the use of the restraint 21. Sample C.5 Crisis Intervention Restraints (off-campus) - this was a 100% sample that included the one instance of off-campus restraint. Documentation provided included the restraint checklist; face-to-face

	assessment/debriefing forms; physician restrictions, if any; documentation of any changes to the Individual's Individual Support Plan (ISP), Positive Behavior Support Plan (PBSP), or Crisis Intervention Plan, if any: and documentation associated with the Facility's restraint review processes. 22. Medical/Dental Restraint Checklists and associated documentation for Individual #97 **People Interviewed:** 1. Rueben Nieto, Psychology Manager 2. Lorraine Hinrichs, ICF/IID Director 3. Mary Ramos, QA Director 4. Twelve Direct Support Professionals **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 5/15/13 2. Settlement Agreement Performance Improvement Council (SA-PIC) 5/14/13
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section C. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section C, in conducting its self-assessment, the Facility: ▪ Did not use formal monitoring/auditing tools. The Facility experienced a small number of restraints since the last review and conducted a 100% "desk audit" of required documentation for each restraint episode. Data resulting from these "desk audits" were presented in the self-assessment in a clear and easily understood format that supported the compliance/lack of compliance reported in the self-assessment. These "desk audits" were completed by the Psychology Manager. ▪ The compliance ratings reported by the Facility in its self-assessment were consistent with the compliance ratings determined by the Monitoring Team. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Consistently measured the quality as well as presence of items. ▪ The Facility rated itself as being in compliance with only Provision C.2 of Section C. This was consistent with the Monitoring Team's findings. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as continued staff training in restraint policy and implementation and continued monitoring of restraint episodes and associated documentation. Most action plan items reported a projected completion date of 5/31/13, which the Facility acknowledged was unrealistic. The Monitoring Team encouraged the Facility to set realistic projected completion dates in future Action Plans. ▪ The Facility self-assessment reported noncompliance with six of seven Provisions in Section C.

Consequently, the Facility identified many areas of needed improvement.

- The actions did provide a set of steps likely to lead to compliance with the requirements of this Section although as mentioned above more realistic projected completion dates need to be established for each action plan step.

The Monitoring Team did not identify any significant issues that the self-assessment process did not already discover and report. In its last report, the Monitoring Team suggested a need for more thoroughness in the self-assessment process. This was accomplished.

Summary of Monitor's Assessment:
Restraint use at the Facility occurred infrequently. This review included a 100% sample of crisis intervention and medical restraints.

Restraint review conducted by the Psychology Department identified several instances where restraint was used inappropriately and without clinical justification. Restraint review also identified two instances of restraint application that were questionable and reported them to the Department of Family Protective Services (DFPS) as possible abuse (both were unconfirmed).

The accuracy and completeness of restraint related documentation had deteriorated significantly from that observed at the last review.

Direct care staff knowledge of basic restraint policy was lacking.

For the second consecutive reporting period the Facility reported no use of medical restraint for dental procedures and limited use for medical procedures.

The Facility provided the Monitoring Team with an excellent self-assessment that identified the identical issues found by the Monitoring Team. This included examples where 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	A review of the Trend Analysis Report for April, 2013 showed:	Noncompliance

Type of Restraint	11/1/12 to 4/30/13	5/1/12 to 10/31/12
Personal restraints (physical holds) during a behavioral crisis	5	15
Chemical restraints during a behavioral crisis	1	6
Mechanical restraints during a behavioral crisis	Data not available	Data not available

#	Provision	Assessment of Status	Compliance

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.

TOTAL restraints used in behavioral crisis	6	21
TOTAL individuals restrained in behavioral crisis	4	7
Of the above individuals, those restrained pursuant to a Crisis Intervention Plan	0	0
Medical/dental restraints	6	2
TOTAL individuals restrained for medical/dental reasons	3	2

Prone Restraint
Based on Facility policy review, prone restraint was prohibited.

Based on review of other documentation (trend reports and lists of restraints) prone restraint was not identified.

Three samples, referred to as Sample C.1, C.4, and C.5 were reviewed. (See Documents Reviewed Section above)

Based on a review of the restraint records for individuals in Sample C.1, C.4, and C.5 involving seven Individuals, zero (0%) showed use of prone restraint.

Based on interviews with 12 direct support professionals, only five (42%) were aware of the prohibition on prone restraint. This lack of knowledge on the part of direct care staff should be addressed through regular competency checks.

Other Restraint Requirements
Based on document review, the Facility and State policies do state 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.

The Facility has two separate and distinct policies governing the use of restraint. These are SOP ICF-IID 700-14 The Use of Restraint (7/12) and SOP NR400-20 The Use of Restraint (5/13). The latter is part of the nursing services manual. The requirements contained in these policies are not 100% congruent. For example, NR400-20 does not include the requirements associated with protective mechanical restraint for self-injurious behavior (PMR-SIB) required in State policy. The Facility needs to review each policy and make certain 1) all requirements of State policy are included, and 2)

#	Provision	Assessment of Status	Compliance
		procedural requirements dictated in each policy are consistent within one another. The Facility has policies titled "Premedication for Medical and Dental Procedures", "Use of Mechanical Devices to Prevent Involuntary Self Injury and to Provide Postural Support", and "Pre-treatment and Post-sedation Monitoring." The Facility should consider incorporating the provisions of these policies into the larger more comprehensive Use of Restraint policy so that all relevant requirements related to restraint use are in one place. Restraint records were reviewed for Sample C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: • In two of the seven records (29%), there was documentation showing that the individual posed an immediate and serious threat to self or others. For Individual #15 (restraint 12/13/12), data on the Face-to-Face Assessment and Debriefing (FFAD) form reported the Individual's behavior did not pose an immediate and serious risk of physical harm to self or others. The debriefing section of the form had not been completed by psychology staff; however, data item 1.1 on the FFAD was checked "no" to indicate that the behavior did not constitute a serious and immediate threat. Additionally, the Individual Support Plan Addendum (ISPA) documenting the Interdisciplinary Team (IDT) review of the restraint noted issues with implementation of the Individual's Behavior Support Plan (BSP) after reviewing video of the restraint episode. For Individual #77 (restraint 2/24/13), the psychology manager, in completing the debriefing section of the FFAD, noted that it would have been better to "just wait him out, only restrain when it is serious" suggesting to the Monitoring Team the behavioral event had not escalated to the point of needing restraint. For Individuals #140 (restraint 10/29/12), #44 (restraint 12/5/12), and #40 (restraint 11/19/12) the debriefing was not completed, so the Monitoring Team did not have enough information to determine if the behavioral event had escalated to the point of needing restraint. For the seven restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that two (29%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. For restraint of Individuals #15 (12/3/12), #140 (10/29/12), #44 (12/5/12), and #40 (11/19/12), the debriefing was not completed so the Monitoring Team did not have enough information to determine if the behavioral event had escalated to the point of needing restraint. The absence of information leaves open the question of whether or not restraint was necessary or was being done for the	

#	Provision	Assessment of Status	Compliance
		convenience of staff and without clinical justification. For Individual #77 (restraint 2/24/13) the psychology manager, in completing the debriefing section of the FFAD, noted that it would have been better to "just wait him out, only restrain when it is serious" suggesting to the Monitoring Team restraint may have been used for the convenience of staff and without clinical justification. • In two of the records (29%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Refer to the examples above. • Facility policies do identify a list of approved restraints. • Based on the review of seven restraints, involving five individuals, seven (100%) were approved restraints. The Facility reported it did not use Physical Mechanical Restraint for Self-Injurious Behavior (PMR-SIB). As noted in previous reports, 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. Documentation reviewed by the Monitoring Team, and interviews, confirmed this process is regularly used in reviewing restraint data which helps in understanding whether or not restraint use was "in accordance with applicable written policies, procedures, and plans governing restraint use." The issues with restraint use reported above by the Monitoring Team had been noted in the Facility's self-assessment. Based on this review the Monitoring Team determined this Provision was not in compliance. This was consistent with the Facility's self-assessment.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the five Individuals in Sample C.1 were reviewed. Of these, none of the individuals had Crisis Intervention Plans that defined the use of restraint. For the five Individuals who did not have Crisis Intervention Plans, five (100%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	Substantial Compliance
C3	Commencing within six months of	The Facility's policies related to restraint are discussed above with regard to Section C.1	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	of the Settlement Agreement. Review of the Facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. Sample C.2 was selected from a current list of staff. See description of Sample C.2 in Documents Reviewed above. A sample of 25 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that • 23 of the 25 (92%) had current training (as part of new employee orientation or as refresher training within the last 12 months) in RES0105 Restraint Prevention and Rules. • 24 of the 25 (96%) had completed all required PMAB training (as part of new employee orientation or as refresher training within the last 12 months). • 23 of the 25 (92%) had completed Positive Behavior Support training (as part of new employee orientation or as refresher training within the last 12 months). In order to evaluate staff knowledge in the area of restraint, 12 Direct Care Professionals were asked a series of questions. The 12 staff were selected by the Facility and included both am and pm staff, and staff from both residential buildings. Each response was evaluated by one member of the Monitoring Team, the Facility's QA Director, and the Facility's Human Rights Officer. Consequently, for each question 36 responses were evaluated. Based on responses to questions, 12 direct support professionals provided satisfactory responses to the following questions as follows: • "Policies governing the use of restraint require that restraint should only be used if the Individual poses a _____and after_____." Eight of 36 responses were evaluated as satisfactory (22%); • "Describe an example of a verbal redirection technique." 26 of 36 responses were evaluated as satisfactory (72%); • "Describe two restraint techniques approved for use at the Facility." 27 of 36 responses were evaluated as satisfactory (75%); • "What level of supervision is usually required when an Individual is in restraint?"	

#	Provision	Assessment of Status	Compliance
		14 of 36 responses were evaluated as satisfactory (39%); and, • "Under what circumstances is it OK to use prone restraint?" 14 of 36 responses were evaluated as satisfactory (39%). The above data suggests staff is not retaining information learned in formal training classes. The Facility needs to engage in additional strategies to reinforce key provisions of restraint policy. Lack of staff knowledge retained from training, at least as demonstrated by this sample of employees, could have a negative effect on future compliance with this Provision. Staff should be able to articulate that restraint is only to be used if the individual poses an immediate and serious risk of harm to him/herself or others and after a graduated range of less restrictive measures has been exhausted, state at least one example of a verbal redirection technique, two examples of approved restraint techniques, that 1:1 supervision is ordinarily required when a person is in restraint, and that there is no circumstance where prone restraint is allowable. As noted above with regard to Provision C.1 only 29% of the restraint records reviewed showed that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. This is consistent with the lack of retention of knowledge that was found in the responses to questions. Based on this review the Monitoring Team determined this Provision was in not in substantial compliance. This was consistent with the Facility's self-assessment. Completion rates for required training classes were satisfactory. Documentation reviewed by the Monitoring Team determined that restraint used was not always the least restrictive intervention necessary to manage behaviors.	
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	Based on a review of seven restraint records (Sample C.1), in two (29%) there was evidence that documented that restraint was used as a crisis intervention. Please refer to the data presented in Provision C.1. In review of five Positive Behavior Support Plans associated with Sample C.1, in five (100%), there was no evidence that restraint was to be used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). In addition, Facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. In seven of seven restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the	Noncompliance

#	Provision	Assessment of Status	Compliance
	eliminate the need for restraint.	"Do Not Restrain" list maintained by the facility. In none of seven restraint records reviewed (0%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to a comparison of the Annual Medical Assessment Active Problems list and the form used by the facility to document restraint considerations/restrictions. Only one of the restraint records reviewed in Samples C.1, C.2, and C.3 contained the form the Facility required to demonstrate compliance with this requirement (Considerations for Implementing Restraint) and this one was not completed correctly. From interview, the ICF-IID Director reported consistent implementation of this requirement had not as yet been addressed by the Facility. In none of seven restraint records reviewed (0%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan according to a comparison of the form used by the Facility to document restraint considerations/restrictions and subsequent action/inaction by the IDT. Refer to the above paragraph. Two Individuals experienced medical restraint, each twice during this review period. In reviewing two ISPs for these two individuals for whom restraint had been used for the completion of medical or dental work: • Two (100%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent); and • Neither (0%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. • Both were in response to emergency treatments needed to respond to an injury. The Facility reported no use of planned pre-treatment sedation for medical or dental procedures or any use of TIVA for dental procedures. The Monitoring Team reviewed Medical/Dental Restraint Checklists for Individual #97. This Individual was not listed on the restraint log provided by the Facility. It appeared the IDT was conflicted as to whether the restrictive practice they had approved (use of a compression suit) represented medical restraint, crisis intervention restraint, or neither. The restrictive practice was in place intermittently for one week in April. Medical restraint checklists and crisis intervention FFADs were partially completed to attempt to document use of the restrictive practice. Neither provided enough data for the Monitoring Team to understand the restraint related circumstances under which this restrictive practice occurred. Refer to Sections K and M for additional information as to the clinical considerations and treatment plans for this Individual.	

#	Provision	Assessment of Status	Compliance
		Based on this review the Monitoring Team determined this Provision was not in compliance. This was consistent with the Facility's self-assessment, which determined that three restraints had not met the criteria for restraints being used for crisis intervention.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	Review of Facility training documentation showed that there was not an adequate training curriculum on the application and assessment of restraint. The Facility was unable to describe or provide documentation that was Facility specific with regard to Restraint Monitor training. In previous reports the Monitoring Team noted that Restraint Monitors successfully completed 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. No evidence was provided during this review to validate this practice had continued. RGSC restraint policy requires that restraint monitors complete the following training, and this training was competency-based. 1. PBS0100 Positive Behavior Support 2. PMA0320 PMAB Basic 3. PMA0400 PMAB Restraint 4. PMA0700 PMAB Prevention 5. RES0105 Restraint: Prevention and Rules for Use at MR Facilities 6. CPR0100 Basic 7. RIG0100 Rights of Consumers 8. ABU0100 Abuse and Neglect Based on review of training records, one of four (25%) staff at the Facility who performed the duties of a restraint monitor successfully completed the training classes referenced above. Training records showed that three had not completed required CPR training and two had not completed required PMAB training. Based on a review of seven restraint records (Sample C.1), a face-to-face assessment was conducted: • In one out of seven incidents of restraint (14%) the assessment was conducted by an adequately trained staff member. • In seven out of seven instances (100%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Note: the Facility self-assessment reported a compliance rate of only 69%. Since the Monitoring Team reviewed a 100% sample this conflicting data is of concern. • In seven instances (100%), the documentation showed that an assessment was	Noncompliance

#	Provision	Assessment of Status	Compliance
		completed of the application of the restraint. • In two instances (29%), the documentation showed that an assessment was completed of the circumstances of the restraint. Physicians had not ordered alternative monitoring schedules for any Individual subjected to restraint. Based on a review of seven restraint records for restraints that occurred at the Facility (Sample C.1), there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint in five of seven (71%) of the instance of restraint. Records that did not contain documentation of this included: o Individual #10: On 2/24/12 at 5:45 p.m., was not assessed. o Individual #44: On 1/11/12 at 11:00 a.m., was not assessed within 30 minutes of application of the physical restraint. • Monitored and documented vital signs in four of seven (57%). Records that did not contain documentation of this included: o Individual #10: On 2/24/13 at 5:45 p.m., no vital signs were assessed. o Individual #14: On 12/3/12 at 11:00 a.m., vital signs were documented as refused. o Individual #40: On 11/19/12 at 7:30 p.m., vital signs were documented as refused. The nurses documented the above individuals "refused" on the restraint checklist. There was no documentation regarding what assessments were attempted. Merely documenting "refused" is not acceptable. Respirations should be obtained; they do not require an individual's cooperation and the nurse should be able to determine whether the individual was having any respiratory distress. • Monitored and documented mental status in six of seven (86%). Records that did not contain documentation of this included: o Individual #10: On 2/24/13 at 5:45 p.m., no mental status assessments were completed. • Documented on the injury section of the restraint checklist for four of seven (57%). No injuries were reported as a result of the physical restraints. Three of seven (43%) restraint checklists did not contain documentation on the injury section. Therefore, for it was not possible to determine whether Individuals: #10, #140, and #40 sustained and injury while physical restrained. The nursing staff needs retraining on the Crisis Intervention Restraint Policy and Restraint Checklist.	

#	Provision	Assessment of Status	Compliance
		Based on documentation provided by the Facility, one restraint had occurred off the grounds of the Facility in the last six months. A sample of one was reviewed (Sample C.5). This was a crisis intervention chemical restraint pursuant to a doctor's order. A licensed health care professional: • Conducted monitoring within 15 minutes of the individual's return to the Facility. • Monitored and documented vital signs in zero of one (0%). Records that did not contain documentation of this included: o Individual #140: On 10/3/13 at 4:35 p.m. Vital signs were assessed initially and again approximately three hours later. Vital signs should have been assessed every 15 minutes for at least two hours post-chemical restraint. • Monitored and documented mental status in zero of one (0%). Records that did not contain documentation of this included: o Individual #140: On 10/3/13 at 4:35 p.m. Mental status was assessed initially and again approximately three hours later. Mental status should have been assessed every 15 minutes for at least two hours post-chemical restraint. Sample C.3 was selected from the list of individuals who had medical restraint in the last six months. It represents 100% of the individuals for whom medical restraint was used. (See Sample C.3 above) For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. • In four out of four (100%), the physician specified the schedule of monitoring required; and • In four out of four (100%), the physician specified the type of monitoring required. Based on this review the Monitoring Team determined this Provision was not in compliance. This was consistent with the Facility's self-assessment.	
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	A sample (Sample C.1) of seven Restraint Checklists for individuals in physical restraint was selected for review. The following compliance rates were identified for each of the required elements: • In seven (100%), continuous one-to-one supervision was provided. • In seven (100%), the date and time restraint was begun. • In seven (100%), the location of the restraint. • In six (86%), information about what happened before, including the change in the behavior that led to the use of restraint. For Individual #44 the description states "was having a behavior" without describing the nature of the behavior.	Noncompliance

#	Provision	Assessment of Status	Compliance
	enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	• In two (28%), the actions taken by staff prior to the use of restraint to permit adequate review as required by Provision C.8. Refer to Provision C.1 for examples. • In two (28%), the specific reasons for the use of the restraint. Refer to Provision C.1 for examples. • In seven (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; • In seven (100%), the names of staff involved in the restraint episode; • All restraints (100%) were of short duration. None required observations at least every 15 minutes and there was no obvious need for staff to provide, during the restraint, opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. • In seven (100%), the level of supervision provided during the restraint episode; • In seven (100%), the date and time the individual was released from restraint; and • In four (57%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. In a sample of seven records (Sample C.1), restraint debriefing forms had been completed for four (57%). A sample of two individuals subject to medical restraint was reviewed (Sample C.3), and in two (100%), there was evidence that the monitoring had been completed as required by the physician's order. Sample C.4 was selected using the list the Facility provided of individuals who had had chemical restraint since the last on-site review. This sample of three individuals who were the subject of a chemical restraint was reviewed. In none (0%), was there documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. Based on this review the Monitoring Team determined this Provision was not in compliance. This was consistent with the Facility's self-assessment. In its last report the Monitoring Team noted that the Facility demonstrated significant improvement towards achieving compliance with this Provision. No further progress towards compliance was noted during this review.	

#	Provision	Assessment of Status	Compliance
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:	According to Facility documentation, during the six-month period prior to the on-site review, there were no Individuals placed in restraint more than three times in any rolling thirty-day period. As a result there was no review activity for this Provision and no compliance rating.	Not rated
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;		Not rated
	(b) review possibly contributing environmental conditions;		Not rated
	(c) review or perform structural assessments of the behavior provoking restraints;		Not rated
	(d) review or perform functional assessments of the behavior provoking restraints;		Not rated
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the		Not rated

#	Provision	Assessment of Status	Compliance
	individual's ISP;		
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and		Not rated
	(g) as necessary, assess and revise the PBSP.		Not rated
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	The Facility had an organized 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. 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. The Monitoring Team could not validate that the IMRT, at the time of its review, had sufficient behavioral and other observational data, to accurately determine "the circumstances under which restraint was used". A Corrective Action Plan (CAP) related to a restraint episode reviewed at an IMRT meeting may be initiated. When this occurs the Incident Management Coordinator tracks the CAP 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. The restraint use is also reviewed by the Individual's IDT within three days of occurrence. If a restraint is recorded by the Facility's video surveillance system, the video is sometimes reviewed; however, the observations of the video review of the restraint episode are not formally documented (for example, on a video restraint review form). Video review can provide additional opportunities for staff training and to validate data recorded on the RC and FFAD was accurate, and if not, could be corrected.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Documentation of restraint review is recorded in IMRT meeting minutes but, as described above, the minutes did 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. This was often not completed. Restraint related issues were routinely referred to the Interdisciplinary Team (IDT) and the results of IDT review were routinely documented in an Individual Support Plan Addendum (ISPA) that became part of the permanent record. A sample of documentation related to seven incidents of physical restraint was reviewed (Sample C.1), including the Unit Team and IMRT meeting minutes, ISP addenda, debriefing meeting minutes, etc.]. This documentation showed that: • In two (29%), the review by the Unit IDT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist. • In two (29%), the review by the IMRT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist. • In seven (100%), the circumstances under which the restraint was used were determined and documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review • In none (0%), the review conducted by the Unit IDT and the IMRT was sufficient to determine if the application of restraint was justified; if the restraint was applied correctly; and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. • In four (57%), referrals were made to the IDT, as appropriate; and • Of the four referred to the IDT, in all four (100%) appropriate changes were made to the individuals' ISPs and/or PBSPs. Sample C.4 included three chemical restraints. In two (67%) of the chemical restraints, the clinical review conducted by the pharmacist and psychiatrist was sufficiently detailed to determine whether the chemical restraint was used in a clinically justified manner; that medication related risks were considered prior to the use of the chemical restraint; of the apparent effectiveness of the chemical restraint in reducing the dangerous behavior in the hours after administration; and that relevant recommendations were made by the pharmacist and the psychiatrist. This information was correctly documented on the Chemical Restraint Consult Form and was signed by the pharmacist and the psychiatrist. An example where this review did not occur was restraint of	

#	Provision	Assessment of Status	Compliance
		Individual #77. The Facility provided minutes of the one meeting of the Reduction of Restraint & Seclusion Workgroup in the last six months. Restraint procedures used in the sample were reviewed at this meeting. Based on this review the Monitoring Team determined this Provision was not in compliance. This was consistent with the Facility's self-assessment.	

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. Regularly "quiz" staff on key elements of restraint policy (Provisions C.1 and C.3)
5. Ensure staff designated as restraint monitors are adequately trained (Provision C.4)
6. Improve procedures related to medical restraint and document accordingly (Provisions C.4, C.5 and C.6)
7. Conduct a review of Facility policies that govern the use of restraint to make certain 1) all requirements of State policy are included, and 2) procedural requirements dictated in each policy are consistent within one another (Provisions C.1, C.3, C.4, C.5, C.6, and C.8).

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Self-Assessment 4/29/13 2. RGSC Action Plan 4/25/13 3. RGSC Section D Presentation Book 4. RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation (2/13) 5. RGSC SOP ICF-IID 200-03 Incident Management (12/12) 6. RGSC SOP ICF-IID 400-01 Injuries to Consumers (7/12) 7. DADS Policy 2.1 Protection From Harm - Abuse, Neglect, and Exploitation 5/11/11 8. DADS Policy 2.2 Incident Management 11/20/12 9. DADS State Supported Living Center Procedure: Injury Audits (undated) 10. Poster used to inform staff, individuals, LARs, and visitors of A/N reporting responsibilities and related monitoring reports from March and April, 2013 11. Criminal Background Check Due Diligence Report from DADS (9/12) 12. DADS ANE Training Curriculum 13. Training transcripts of Facility and Department of Family Protective Services (DFPS) investigators 14. DFPS Investigator Training Outlines and Competency Tests (undated) 15. Acknowledgement of Responsibility for Reporting Abuse, Neglect, and Exploitation forms for sample of 25 employees (Sample C.2) 16. RGSC Unusual Incident Investigation Review Checklist (11/14/11) 17. List of Peer caused injuries 9/1/12 to 2/28/13 18. Witnessed Injury Log 9/1/12 to 4/30/13 19. Discovered Injury Log 9/1/12 to 4/30/13 20. Unusual Incident Log 9/1/12 to 5/10/13 21. Serious Injury Log 9/1/12 to 5/10/13 22. DFPS Investigation case Log 9/1/12 to 5/10/13 23. OIG Investigation case Log 9/1/12 to 5/10/13 24. Material used to educate guardians on abuse reporting (2/12) 25. Sample documentation of employee discipline taken post investigation 26. Incident Management Review Team (IMRT) minutes for meetings from 9/1/12 to 4/30/13 27. Independent Ombudsman Annual Report for 2012 28. Self-Advocates meeting minutes 6/12 through 3/13 29. Meeting minutes: DFPS/OIG/RGSC Quarterly Coordination meeting held 8/29/12, 12/7/12, and 3/13/13 30. Injury Audit Record Reviews for February (2), March (3), and April (5), 2013 31. Training transcripts for sample of 25 staff (Sample C.2) 32. Training transcripts for Facility and DFPS Investigators 33. Customer Satisfaction Survey (6/30/12)

	34. Sample D.1: included a sample of five DFPS investigations of abuse, neglect, and/or exploitation (with the companion Facility investigation reports) that were selected from the log of DFPS cases from 9/1/12 through 2/28/13. The sample was 20% of reported investigations and represented investigations that resulted in confirmed, unconfirmed, and inconclusive Investigation records included: cases 42590192, 42599122, 42604305, 42619492, and 42662513. 35. Sample D.2: included a sample of six investigation reports completed only by the Facility that was selected from the log of serious injuries from 9/1/12 through 2/28/13. The sample was 20% of reported investigations. Investigation records included UIRs 13-004, 010, 013, 017, 019, and 021. 36. Sample D.3: included a sample of six non-serious discovered injuries selected from the log of discovered injuries from 9/1/12 to 2/28/13. These included injuries to Individuals #51 (9/24/12), #139 (2/27/13), #40 (2/13/13), #108 (12/6/12), #82 (10/7/12), and #1 (1/22/13). 37. Sample D.4: included 12 Individual Support Plans (ISPs) for Individuals #40, #140, #44, #77,#19, #47, #79, #126, #1, #15, #149, and #12 38. Sample of 10 reported allegations returned by DFPS as Administrative Referrals **People Interviewed:** 1. Myrna Wolfe, Incident Management Coordinator (IMC) 2. Mary Ramos, Quality Management Director 3. Omar Mendiola, DFPS Inspector 4. Lorraine Hinrichs, ICF/IID Director 5. Juan Gonzalez, Program Improvement Manager 6. George Romero, QDDP Manager 7. Twelve Direct Support Professionals **Meetings Attended:** 1. Incident Management Review Team (IMRT) 5/15/13 2. Settlement Agreement Performance Improvement Council (SA-PIC) 5/14/13 3. RGSC self-advocates meeting 5/15/13
	Facility Self-Assessment: The RGSC Self-Assessment indicated the Facility was in substantial compliance with 22 of the 22 provisions in Section D of the Settlement Agreement. The Monitoring Team found the Facility to be in compliance with 21 of the 22. The Facility submitted a Self-Assessment for Section D. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section D, in conducting its self-assessment, the Facility: • Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: the Section D DADS Monitoring Tool, RGSC Quality Review tool on the Completeness

	of UIRs, ANE Competency Audit form, Unusual Incident Investigation Review Checklist, UIR Audit Tool, Audit of Implementation of UIR Recommendations, CAP Effectiveness Audits, and Findings Reports completed by campus coordinators. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as observations, interviews, record reviews. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). Sample sizes were either 20% of the N or 100% samples. The sample sizes were adequate to consider them representative samples. o The monitoring/audit tools did not have adequate written instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: QE Coordinator, Incident Management Coordinator, Human Rights Officer, Health Information Management staff, and Program Specialists/Campus Coordinators. o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically/programmatically competent in the relevant area(s). o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools; however, inter-rater reliability data was not presented in the self-assessment. • The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators and used these data in initiating corrective actions o Consistently measured the quality as well as presence of items. • The Facility rated itself as being in compliance with all 22 Provisions of Section D. The Monitoring Team found the Facility to be in compliance with 21 Provisions, the exception being Provision D.2.i. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve continued compliance. • Actions were reported as continued audit reviews and commensurate corrective action plans. • The Facility data identified areas of needed improvement. The Facility's defined processes for auditing the administrative requirements associated with Section D compliance appeared to be sufficient to conduct future self-assessments • The actions did provide a set of steps likely to lead to compliance with the requirements of this Section.

	Summary of Monitor's Assessment: During this review, the Monitoring Team found the Facility to be in compliance with 21 out of 22 provisions of Section D, as opposed to 15 provisions that were in compliance during the last review. Progress was noted in a number of areas. Highlights of progress included: 1. Improvement in timely reporting of incidents (Provision D.2.a) 2. Improvement in timely identification of alleged perpetrators (Provision D.2.b) 3. Improvement in investigation procedures and conclusions (Provision D.3.f) 4. Improvement in investigation review practices (Provision D.3.g) 5. Improvement in documenting investigation review (Provision D.3.h) 6. Initiation of audits to measure the outcomes associated with administrative and programmatic actions resulting from investigation review follow-up (Provision D.3.i) Provision D.2.i remains out of compliance but significant actions had been taken which should lead to compliance. The Facility is to be commended for its steady improvement in reaching compliance with Section D requirements. In the past three reviews the number of compliant Provisions has gone from 11 to 15 to 21. The internal management and monitoring systems in place at RGSC were self-identifying instances of noncompliance with policy and procedure, especially in areas where clear data parameters exist such as the timeframes associated with reporting, with initiating investigations, and with completing investigations. These issues were immediately addressed when identified. The IMRT process was in place and functions as a review body, meets daily, and its minutes reflects review of injuries, incidents, and investigation reports. 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. 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. 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. Staff training requirements were current. The Facility had an ongoing system for on-the-spot competency testing to ensure staff retains the key requirements of abuse/neglect training. This process needs improvement as the Monitoring Team met with 12 Direct Support Professionals (DSPs) whose knowledge of some of the basic principles associated with abuse and neglect reporting was disappointing. Self-advocate meetings were held monthly and were well attended. Abuse and neglect reporting was

	reviewed at each meeting as a means of providing ongoing education to individuals. All allegations of physical abuse were appropriately referred to law enforcement. The DFPS Investigator interviewed expressed a high level of cooperation between Facility administrative staff and themselves. The Facility had made office space available to DFPS, and DFPS had an investigator working out of this office on a regular basis. This facilitates timely 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. Presentation of information in UIRs was well organized in a manner that ensured all the requirements of the SA can be readily identified to determine compliance. Facility review of investigations ensured that the investigations were thorough and complete and that reports were accurate, complete and coherent. 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. Tracking and trending data was complete and regularly analyzed. 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.	The Facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. 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. 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	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>illustrated by examples provided throughout this Section D of the report.

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.

Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.</td><td></td></tr>
<tr><td>D2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:</td><td></td><td></td></tr>
<tr><td></td><td>(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.</td><td>According to RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation, staff were required to report abuse, neglect, and exploitation within one hour by calling the DFPS 1-800 number. This was consistent with the requirements of the Settlement Agreement.

With regard to serious incidents, the Facility policy entitled RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation, required staff to report serious incidents within one hour of discovery. The process for staff to report such incidents required staff to notify the Facility Director/designee. This policy was consistent with the requirements of the Settlement Agreement.

According to data the Facility provided in response to the Document Request the numbers of abuse/neglect/exploitation allegations for the past two years were:

<table><tr><th></th><th>5/1/12 to 4/30/13 (recent 12 months)</th><th>5/1/11 to 4/30/12 (earlier 12 months)</th></tr><tr><td>Total physical abuse allegations</td><td>34</td><td>80</td></tr><tr><td>Number confirmed</td><td>0</td><td>8</td></tr><tr><td>Number inconclusive</td><td>1</td><td>13</td></tr><tr><td>Total verbal abuse allegations</td><td>7</td><td>16</td></tr></table></td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Number confirmed	1	1
Number inconclusive	1	0
Total neglect allegations	32	80
Number confirmed	2	15
Number inconclusive	0	3
Total exploitation allegations	2	3
Number confirmed	0	0
Number inconclusive	0	0

According to Facility data provided in response to the Document Request the numbers of Unusual Incidents investigated over the past two years included:

	5/1/12 to 4/30/13 (12 months)	5/1/11 to 4/30/12 (12 months)
Deaths	0	1
Serious Injuries	17	12
Sexual Incidents	2	1
Suicide Threat (credible)	0	0
Unauthorized Departure	4	3
Choking	3	2
Other	0	0

In order to evaluate staff knowledge in the area of abuse and neglect 12 Direct Care Professionals were asked a series of questions. The 12 staff were selected by the Facility and included both am and pm staff, and staff from both residential buildings. Each response was evaluated by one member of the Monitoring Team, the Facility's QA Director, and the Facility's Human Rights Officer. Consequently, for each question 36 responses were evaluated.

Based on responses to questions, 12 direct support professionals provided satisfactory responses to the following questions as follows:

"Describe the reporting procedure and timeframe when abuse/neglect is suspected." 25 of 36 responses were evaluated as satisfactory (69%).

"Describe the reporting procedure and timeframe for other serious incidents." 24 of 36 responses were evaluated as satisfactory (67%).

The above data suggests staff is not retaining information learned in formal training classes. The Facility needs to engage in additional strategies to reinforce key provisions

#	Provision	Assessment of Status	Compliance
		of abuse and serious incident reporting policy. Lack of staff knowledge retained from training, at least as demonstrated by this sample of employees, could have a negative effect on future compliance with this provision. Based on a review of the five investigation reports included in Sample D.1 • Four (80%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. The one that was not was discovered during a scheduled video surveillance quality review and immediately reported. Apparently, when the incident occurred, the video monitor did not see the incident that was subsequently reported. Video monitors have multiple screens to watch and this type of oversight can occasionally occur. The Facility is to be commended for having a video quality review system and that this system detected this oversight. • Five (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by Facility policy. Based on a review of six incident reports included in Sample D.2: • Six (100%) showed evidence that serious incidents were reported within the timeframes required by Facility policy. • Six (100%) showed evidence that serious incidents were reported to the appropriate party as required by Facility policy. The Facility had a standardized reporting format which contains information necessary for adequate follow-up, as well as tracking and trending of incidents. Based on a review of 11 investigation reports included in Sample D.1 and Sample D.2, 11 (100%) contained a copy of the report utilizing the required standardized format. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(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	According to RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation the Facility is required to immediately remove any alleged perpetrator of abuse or neglect from contact with Individuals, placing the effected staff in NDC (no direct contact) status. Additionally, the Facility is to take immediate steps with the affected Individuals such as a nursing assessment and an emotional assessment. Based on a review of five investigation reports included in Sample D.1, five (100%) of alleged perpetrators were removed from direct contact with individuals immediately	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	following the Facility being informed of the allegation. Based on a review of five investigation files included in Sample D.1 five (100%) showed that no staff that had been removed from direct contact were subsequently reinstated prior to the completion of the investigation. Based on a review of five investigation files, it was documented that adequate additional action was taken to protect individuals in five cases (100%). Actions included, for example, medical care, reassignment of roommates, and immediate training for staff. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(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.	According to RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation, required all staff to complete the DADS competency based class on Abuse, Neglect, and Exploitation (ABU0100). This was consistent with the requirements of the Settlement Agreement. A review of the training curricula related to abuse and neglect was reviewed for: a) new employee orientation; and b) annual refresher training. The results of this review were as follows: 39. In relation to the requirement that training is competency-based, the Monitoring Team reviewed the curriculum and determined the training was competency based. 40. The training curriculum did provide adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. Review of 25 staff records (Sample C.2), showed that 25 (100%) of these staff had completed competency-based training on abuse and neglect as part of New Employee Orientation and therefore prior to working directly with individuals. Review of DADS computer reports displaying the percentage of completion for training classes showed that 99% were current in completing A/N training. In order to evaluate staff knowledge in the area of abuse and neglect 12 Direct Care Professionals were asked a series of questions. The 12 staff were selected by the Facility and included both am and pm staff, and staff from both residential buildings. Each response was evaluated by one member of the Monitoring Team, the Facility's QA Director, and the Facility's Human Rights Officer. Consequently, for each question 36 responses were evaluated. Based on responses to questions, 12 direct support professionals provided satisfactory	Substantial Compliance

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		responses to the following questions as follows: "Describe two signs or symptoms of abuse." 36 of 36 responses were evaluated as satisfactory (100%). "Describe two signs or symptoms of neglect." 30 of 36 responses were evaluated as satisfactory (83%). "Describe two other types of serious incidents (other than abuse/neglect) that must be reported." Seven of 36 responses were evaluated as satisfactory (19%). The above data suggests staff is not retaining information learned in formal training classes. The Facility needs to engage in additional strategies to reinforce key provisions of abuse and serious incident reporting policy. Lack of staff knowledge retained from training, at least as demonstrated by this sample of employees, could have a negative effect on future compliance with this provision. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	According to RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation, staff is notified of abuse/neglect reporting responsibilities and must sign an acknowledgment form. This is Form 1020. Copies were requested of the forms for staff hired during the two full months prior to the on-site review. Based on a review of those forms, 100% of staff hired during this time period had signed the acknowledgement form. A sample of 25 staff (Sample #C.2) was randomly selected to determine if annual acknowledgements had been signed. Of the 25, 25 (100%) had signed annual acknowledgments. The Facility was asked for a list of staff that had been identified as having failed to report abuse and/or neglect. This generated a list of two staff. This was identified by the Facility in its review of UIRs. Personnel actions related to these failures were reviewed and in both cases administrative/disciplinary action appropriate to the circumstances was taken. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment. .	Substantial Compliance

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	(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.	According to RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation, IDTs were to provide LARs with written communication on abuse/neglect identification and the reporting process. Additionally, this topic is to be a regular point of discussion at each Individual's ISP meeting. A review was conducted of the materials to be used educate individuals. Materials included necessary information and were easy to understand and available in English and Spanish language versions. A review was conducted of the materials to be used to educate legally authorized representatives (LARs) or others significantly involved in the individual's life. Materials were easy to understand and available in English and Spanish language versions. Based on a review of 12 Individuals' PSPs (Sample #D.4), 12 (100%) Individuals, or their LAR and/or other significantly involved individual had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. It was evident to the Monitoring Team that the ISP process in place at the Facility regularly and routinely covered the topic of abuse/neglect identification and reporting. The Monitoring Team observed the self-advocate meeting held during the week of the review. The meeting was well attended and included review of abuse/neglect identification and reporting. The Facility reported this topic is covered at every meeting of the self-advocates. Additional validation of compliance with this Provision was provided in a survey completed by the Independent Ombudsman which included a four day site review. This survey occurs annually and the survey report was presented to the Facility QA/QI Council. This survey included an interview with 20 Individuals. From this survey it was reported: 8. 100% of respondents reported they had been informed of their rights and could name some of their rights. 9. 75% reported they know what to do if they have a rights concern. 10. 100% reported they are comfortable speaking up for themselves. The survey included a family member component. Family member respondents reported: 4. 100% had been notified of the Individuals rights. 5. 75% know how to file a complaint. Family members and LARs report frequent visiting. In the last customer satisfaction survey 66% responded to the survey and 75% of the respondents reported they visited	Substantial Compliance

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		at least once every three months. 53% reported they visited at least monthly. Eight allegations of abuse or neglect were reported by Individuals, further evidence that they are aware of their rights and exercise them. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(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.	According to RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation, postings directed at compliance with this requirement are to be maintained at all times. A review was completed of the posting the Facility used. It did include a brief and easily understood statement of: 1) individuals' rights; 2) information about how to exercise such rights; and 3) information about how to report violations of such rights. Observations by the Monitoring Team of three of three living units and day programs on campus showed that three (100%) of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. The Facility has on ongoing surveillance process that ensures the presence of posters is maintained. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	According to RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation, allegations of abuse/neglect are to be reported, as appropriate, to law enforcement. Based on a review of five allegation investigations completed by DFPS (Sample D.1), in five for which a referral to law enforcement was necessary/appropriate, the Facility had made referrals in five (100%). In addition to Sample D.1, in reviewing the DFPS case log it was apparent that all instances of alleged physical abuse were routinely referred to law enforcement by DFPS. Based on a review of six investigations completed by the Facility (Sample D.2), in none was a referral to law enforcement necessary/appropriate. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	Substantial Compliance

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	(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.	According to RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation, retaliation against reporters of abuse/neglect is prohibited and not tolerated. Based on interviews with the Facility Director and Assistant Facility Director, these requirements are included in training curriculum and reinforced using postings throughout the Facility. Each stated emphatically that retaliation is not tolerated and when alleged or detected was formally investigated. Twelve Direct Care Professionals were asked two questions regarding retaliation. Their responses were: 1. If you reported abuse or neglect would you worry about being retaliated against by a coworker or supervisor? Eleven of 12 (92%) reported they would not worry about being retaliated against. 2. If retaliation did happen, or was suspected, should it be reported? All 12 answered yes. If so, to whom? All 12 answered correctly (to the Superintendent). As noted in Provision D.2.e in response to a survey conducted by the Independent Ombudsman, 20 of 20 (100%) Individuals interviewed reported they were comfortable in speaking up for themselves. In addition to data reported under Provision D.2.e, these 20 respondents also reported they felt their teams listened to them. This suggests that they could tell staff or call to report that someone had hurt them or not taken care of them, and they would not get into trouble. Based on a review of investigation records (Sample D.1 and Sample D.2), there were not concerns noted related to potential retaliation. The Facility was asked for a list of staff against whom disciplinary action had been taken due to their involvement in retaliatory action against another employee who had in good faith had reported an allegation of abuse/neglect/exploitation. The Facility indicated there were no instances of perceived or actual retaliation reported. Outside investigators (DFPS) reported no concerns with perceived or actual retaliation in the course of their interviews with witnesses. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	Substantial Compliance

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	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	According to RGSC SOP ICR-IID 200-03 Incident Management the Facility is to "review and make use of audits reports that evaluate whether significant resident injuries are reported for investigation at least semi-annually." The Facility had been using the DADS State Supported Living Center procedure for its injury audits. DADS policy establishes a general framework for the review and investigation of injuries. The Monitoring Team was provided with an additional document by DADS titled "State Supported Living Center Procedure: Injury Audits." This procedure reports the following as its purpose: 1. A process to conduct audits of the resident's records to detect incidents which may have resulted in an injury and generate a Client Injury Report (CIR). 2. The proper coding of injuries to residents 3. Decreasing injuries of known or unknown source or origin 4. Ensuring residents remain free from abuse, neglect, or exploitation 5. Compliance with significant injury audit requirements D2i of the Settlement Agreement. The procedure calls for a six month review of a 20% sample of Individuals living at the Center. For RGSC this would require a review of two Individuals per month. The review looks at, at a minimum, Integrated Progress Notes, Home/Shift Logs, Observation Notes, and Campus Coordinator Logs to review and identify incidents that may have resulted in completing an injury report and a UIR. The audit also determines if the injury was coded and investigated (serious injuries and injuries of unknown source) per SSLC Incident Management Policy and Injury Reporting Procedure. This procedure does not specifically require that the Facility review Individuals who had multiple minor injury issues that may represent a pattern or trend that might merit further investigation, either because of the type or body location of injury, location or shift that injuries occur on, a preponderance of discovered injuries, and any other variables that might merit examination and could be potentially useful in reducing the number of injuries incurred by that Individual. In its last two reports 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 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 significantly higher than the average of the other Facilities in the State. The Monitoring	Noncompliance

#	Provision	Assessment of Status	Compliance
		Team continues to believe this is a necessary step to achieve compliance with this Provision. The audit procedure required by DADS had been in place at RGSC and was being administered correctly. The audits did not discover any significant injuries that were not reported and investigated but should have been. Several data system issues were identified and corrected as a result of these audits. Additionally, the Facility had engaged in improved practices in its review activity of non-serious discovered injuries to ensure they were not significant and therefore merited official investigation via the UIR process, or reported to DFPS because of a suspicion of abuse or neglect. The accuracy and completeness of the Facility's review of non-serious injuries had improved significantly from that observed in previous reviews. As described above, still lacking at the Facility was a process which reviewed data associated with frequently injured individuals to assess whether or not the nature of the injuries, the time and/or place of the injuries, or any other factors suggested a need to examine trend data further to assess system causes and trends of injuries to prevent future injuries from occurring. Based on this review the Monitoring Team determined this Provision was not in 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	According to RGSC SOP ICF-IID 200-03 Incident Management the policy: ▪ Did describe in a comprehensive fashion of the conduct of all such investigations; ▪ Did require that investigators be qualified, requiring that Investigators complete training in Comprehensive Investigator Training (CIT0100), People with MR (MEN0300), Conducting Serious Incident Investigations or	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	Fundamentals of Investigation (INV0100, and, a class in Root Cause Analysis. ▪ Did require that investigators have training in working with people with developmental disabilities, including persons with mental retardation; and ▪ Did require that investigators be outside of the direct line of supervision of the alleged perpetrator. Training curricula were reviewed for Department of Family and Protective Services (DFPS) and Facility investigators. This review of material used by DFPS in training its investigators revealed the following: The required class "MH&MR Investigations ILSD" consisted of the following modules: 1. Introduction and History of DFPS, APS, DADS, and DSHS 2. Laws, Rules, & Policies Governing APS MH&MR Investigations 3. Dynamics of Abuse, Neglect, and Exploitation 4. Psychiatric Terms 5. Client Rights 6. Prevention and Management of Aggressive Behavior 7. Evidence Collection 8. Basic Interviewing 9. Interviewing Persons with Developmental Disabilities 10. MH&MR IMPACT Technical Guide 11. Analysis of Evidence 12. Effective Writing 13. Disposition of Cases The required class MH&MR Investigations ILASD included the following modules: 1. Cross-Cultural Interviewing 2. Strengthening the Written Report 3. Deception and Confrontation of Deception 4. Time and Stress Management In reviewing the materials associated with these modules the Monitoring Team is of the opinion that this training is competency-based and meets the requirements of the SA. DADS policy reported that Facility Investigator training is to consist of the following classes: 1. ABU0100 Abuse and Neglect 2. UNU0100 Unusual Incidents 3. MEN0300 People with Mental Retardation 4. CIT0100 Comprehensive Investigator Training, or LRA training Conducting Serious Investigations	

#	Provision	Assessment of Status	Compliance
		5. Root Cause Analysis The Monitoring Team believes this training, if completed as described, was adequate for the conduct of investigations at RGSC, was competency based, and meets the requirements of the SA. The training records for DFPS investigators were reviewed with the following results: ▪ Five out of five DFPS investigators (100%) had completed the requirements for investigations training. ▪ Five out of five DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. The training records for Facility investigators were reviewed with the following results: ▪ Seven out of seven Facility investigators (100%) had completed the requirements for investigations training. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Based on RGSC SOP ICF-IID 200-03 Incident Management, Facility staff was required to cooperate with outside entities conducting investigations of abuse and neglect. This included DFPS and OIG. As described above with regard to Provision D.2.a, two samples of investigation files were selected for review. These included Sample D.1 and Sample D.2, which consisted of DFPS investigations, and Facility investigations, respectively. Review of the investigation files in Sample D.1 showed that in five out of five investigations (100%), Facility staff cooperated with outside entities, including DFPS and OIG. Review of the investigation files in Sample D.2 showed that in six out of six investigations (100%), Facility staff cooperated with any outside entities inquiring about the Facility investigation. Outside investigators (DFPS) reported cooperation from Facility administrative staff in the conduct of their investigations. Finally, the Facility provides an office to DFPS. As a result, a DFPS investigator is onsite five days a week which presumably facilitates cooperation and coordination.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ Of the five investigation records from DFPS (Sample D.1), four (100% of physical abuse allegations) had been referred to law enforcement (Office of Inspector General). For these four (100%) there was adequate coordination to ensure that there was no interference with law enforcement's investigations. ▪ Of the 11 investigation records from the Facility (Samples D.2 and D.3), none had been referred to law enforcement agencies because none were appropriate for referral. Outside investigators (DFPS) reported no issues associated with the coordination of investigatory activity either between the outside agencies or with the Facility. As an added measure to ensure inter-agency communication, the Facility convenes a quarterly meeting with DFPS and OIG to discuss, among other things, any issues which may affect compliance with this Provision. Finally, the Facility provides an office to DFPS. As a result, a DFPS investigator is onsite five days a week which presumably facilitates cooperation and coordination. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	According to RGSC SOP ICF-IID 200-03 Incident Management, the Facility is to take steps to preserve physical evidence and should prioritize the collection of evidence that is most at risk of contamination (the Facility policy further states that "in most cases the highest priority will be to identify interviewees and physically separate them until they have	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		been interviewed." This statement is also in DADS policy.). While on site, the Monitoring Team observed the area the Facility uses for safeguarding physical evidence. Evidence was stored in a secure area. The DFPS investigator interviewed as part of this review reported no issues at the Facility with evidence collection and protection, and in fact highlighted a recent example of important physical evidence he accessed from the Facility. Based on a review of the investigations completed by DFPS (Sample D.1) and the Facility (Samples D.2 and D.3): ▪ Physical evidence that needed to be safeguarded was safeguarded in all DFPS investigations; and ▪ Physical evidence that needed to be safeguarded was safeguarded in all Facility investigations. As noted above, both Facility and DADS policy states "the facility investigator should prioritize the collection of evidence that is most at risk of contamination. In most cases, the highest priority will be to identify interviewees and physically separate them until they have interviewed." Evidence gathered through interview is considered testimonial evidence. With regard to testimonial evidence, the Monitoring Team found little evidence that would suggest that component of the Facility and DADS policy (separation of witnesses until they are interviewed) was being followed. The Facility reported that alleged perpetrators are reassigned away from co-workers, which is a positive step. In reviewing Sample D.1 (DFPS investigations) there was no indication that collateral witnesses had been physically separated pending interview. As a practical matter this would be difficult since DFPS usually does not complete interviews of collateral witnesses or alleged perpetrators (APs) until days after the allegation was reported, sometimes a week or longer. When an AP is placed on No Direct Care (NDC) status they sign an acknowledgment statement but this statement does not include a requirement such as "You are not to discuss the allegations or details of the investigation with anyone other than the investigators." In abuse/neglect training, and unusual incident training, staff is instructed to not discuss with each other any information regarding incidents under investigation. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment. The Facility and DADS should review its policy with respect to testimonial evidence. DADS should provide guidance to the Facility as to how it should be implemented, or change the policy such that it establishes requirements that can be reasonably administered.	

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		Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(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.	Based on RGSC SOP ICF-IID 200-03 Incident Management investigations of serious incidents: ▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were to be completed within 10 calendar days of the incident; ▪ Did require a written extension request from the Facility Superintendent or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ Five of five (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. The following are examples of investigations in which adequate investigatory process occurred within the first 24 hours or sooner, if necessary: telephone contact with the Facility's Incident Management Coordinator or Campus Coordinator to ensure the individual who is the subject of the report is safe (and if injured has received appropriate medical care) , that any known APs were placed in NDC status, the identification of any collateral witnesses, that the Facility has (or is) gathering all relevant documentation, that any physical evidence is secure, a determination if there is likely video surveillance evidence to review, and the development and review of a preliminary investigation plan. ▪ Five out of six (83%) were completed within 10 calendar days of the incident, including sign-off by the supervisor; ▪ For the one that was not completed within 10 days, one (100%) had documentation of a written extension request that had been approved by the Facility Superintendent, and there was documentation of the extraordinary	Substantial Compliance

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		circumstances that necessitated the extension. ▪ Six (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In six of the investigations reviewed, recommendations for corrective action were included. In six of the investigations (100%), the recommendations were adequate to address the findings of the investigation. The following are examples of investigations that included appropriate recommendations: o UIR13-004 included 10 recommended actions that included environmental improvements, staff training, and IDT review. o UIR13-010 included 10 recommended actions that included PNMT changes, staff training, and clinical reviews. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(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	Based on a review of RGSC SOP ICF-IID 200-03 Incident Management the policy did require that: ▪ The contents of the investigation report be sufficient to provide a clear basis for its conclusion; ▪ The report utilize a standardized format that sets forth explicitly and separately: o Each serious incident or allegations of wrongdoing; o The name(s) of all witnesses; o The name(s) of all alleged victims and perpetrators; o The names of all persons interviewed during the investigation; o For each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o All documents reviewed during the investigation; o All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o The investigator's findings; and o The investigator's reasons for his/her conclusions. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately.	Substantial Compliance

#	Provision	Assessment of Status	Compliance

	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>DFPS Investigations</u>
		The following summarizes the results of the review of DFPS investigations:
		▪ In five out of five investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.
		▪ The report utilized a standardized format that set forth explicitly and separately
		o In five (100%), each serious incident or allegations of wrongdoing;
		o In five (100%), the name(s) of all witnesses;
		o In five (100%), the name(s) of all alleged victims and perpetrators;
		o In five (100%), the names of all persons interviewed during the investigation;
		o In five (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;
		o In five (100%), all documents reviewed during the investigation;
		o In five (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victi five m(s) and perpetrator(s) known to the investigating agency;
		o In five (100%), the investigator's findings; and
		o In five (100%), the investigator's reasons for his/her conclusions.
		
		<u>Facility Investigations</u>
		The following summarizes the results of the review of Facility investigations:
		▪ In six out of six investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.
		▪ The report utilized a standardized format that set forth explicitly and separately
		o In six (100%), each serious incident or allegations of wrongdoing;
		o In six (100%), the name(s) of all witnesses;
		o In six (100%), the name(s) of all alleged victims and perpetrators;
		o In six (100%), the names of all persons interviewed during the investigation;
		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;
		o In six (100%), all documents reviewed during the investigation;
		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;
		o In six (100%), the investigator's findings; and
		o In six (100%), the investigator's reasons for his/her conclusions.	

#	Provision	Assessment of Status	Compliance
		Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(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.	RGSC SOP ICF-IID 200-03 Incident Management did require that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete and coherent. The policy did require that any further inquiries or deficiencies be addressed promptly. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In five out of five investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report. ▪ In five (100%), there was evidence that the review had resulted, if needed, in changes being made to correct deficiencies or complete further inquiry. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In six out of six investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report. ▪ In six (100%), there was evidence that the review had resulted, if needed, in changes being made to correct deficiencies or complete further inquiry. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	Substantial Compliance
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The Facility prepared a written report addressing each investigation deficiency or area needing further inquiry discovered pursuant to the provisions of subparagraph g. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic	According to RGSC SOP ICF-IID 200-03 Incident Management disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence was	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	to be taken promptly and thoroughly. In addition, the Facility used its Corrective Action Plan (CAP) process (refer to Section E of this report for a complete description of this process) for tracking and documenting the implementation of disciplinary and programmatic actions developed in response to investigation report review activity. The status of CAP implementation is regularly reviewed by the QA Department and reports are prepared for review at the monthly Settlement Agreement Program Improvement Council (SA-PIC). The Facility had also initiated a process for CAP effectiveness audits (refer to Section E of this report for a complete description of this process). Over time, this process will be able to determine whether disciplinary or programmatic actions initiated after review of investigation reports corrected the situation and/or prevented recurrence. Material reviewed by the Monitoring Team for both of the above processes appears adequate to ensure ongoing compliance with this Provision. In order to determine compliance with this provision of the Settlement Agreement, Sample D.1 and Sample D.2, were reviewed. Documentation was requested to show what follow-up had been completed to address the recommendations resulting from these investigations. In addition, while the Monitoring Team was on site, some observations and interviews with staff were conducted to determine if adequate follow-up had occurred for some of the investigations included in the samples. For 11 out of 11 of the investigations reviewed (100%), when disciplinary action was appropriate prompt and adequate disciplinary action had been taken and documented. The Facility had no confirmed findings related to abuse; however, in several cases employees were provided with positive performance counseling related to the events surrounding the incident and investigation. For 11 out of 11 of the investigations reviewed (100%), when programmatic action was appropriate, prompt and adequate programmatic action had been taken and documented. This included, among other things, additional staff training, environmental changes, and additional IDT reviews and changes to program plans. In reviewing Samples D.1 and D.2 the Monitoring Team did not identify any instance where it appeared disciplinary or programmatic action should have been taken and was not. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(j) Require that records of the	Based on review of RGSC SOP ICF-IID 200-03, Incident Management records of every	Substantial

#	Provision	Assessment of Status	Compliance
	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.	investigation are to be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual. At the Facility, electronic data systems are maintained which allow the IMC to sort investigation records by name of the alleged perpetrator or by name of the alleged victim. The IMC reported that DFPS also has a data management system that allows a search of prior case history of alleged perpetrators and alleged victims. Additionally, DFPS, if necessary, can obtain these data from the Facility. For Facility investigations, these data are included in the UIR template which enables the Facility investigator to determine its relevance to each investigation. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	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.	The Facility maintained an extensive data system which included all 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. These data were used, in part, in looking at trends related to specific staff or specific individuals in the context of specific incidents being investigated.. 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 several years ago by the Facility to encourage those reviewing data reports to engage in critical thinking. Trend data associated with unusual incidents and investigation results is reviewed using this system. 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 using it to identify and address perceived systemic issues that may be barriers to protecting individuals from harm. With respect to the tracking and trending of unusual incident (and restraint) data by Individual, the Facility has the ability to incorporate these data into ISP planning and appears to at least routinely consider it. The ISP Meeting Guide which is prepared prior to an ISP meeting and is intended to provide the IDT with all relevant assessment information, relevant data, and anecdotal information includes data and graphs on injuries, falls, allegations, etc. More detailed data can be extracted from databases by the QDDP. It was unclear to the Monitoring Team if these data actually impact the ISP for the	

#	Provision	Assessment of Status	Compliance
		following year. For example, Individual #134 had an ISP the week of the review. The pre-planning document noted he had five injuries (shaving cuts and abrasions) during the last year. The ISP meeting did not discuss the Individual's shaving and how it might be adjusted to be safer. Another Individual was reported to make repeated false allegations to DFPS. It was unclear if this was directly addressed in the ISP planning. A pattern of false allegations would be a barrier to community placement and should be addressed. The Facility could probably make better use of this detailed data that is available. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
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.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 25 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to annual fingerprint checks during the month of September, 2012. 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. 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 the Facility Director took appropriate administrative action in each case. In an interview with the Facility Director, her decisions regarding the employment of a	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		sample of applicants with any criminal history were discussed on a case-by-case basis. In each instance, her decisions were based on the facts and were mindful of her responsibility to safeguard the individuals and staff of the Facility. This Provision is in substantial compliance.	

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

1. 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).

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed** 1. RGSC Self-Assessment 4/29/13 2. RGSC Action Plan 4/25/13 3. RGSC Section E Presentation Book 4. DADS Policy 3.1 Quality Assurance 1/26/12 5. RGSC SOP QM 100.14 DADS Quality Assurance Expectations (2/13) 6. RGSC SOP HR 100-07 Compliance With Required Training/Performance Evaluations/Corrective Action Plans/Health Information Management Deficiencies Requiring Action (2/13) 7. RGSC Quality Assurance Plan 4/18/13 8. RGSC Improving Organizational Performance Program 10/1/12 9. Settlement Agreement Performance Improvement Council (SA-PIC) meeting minutes (including extensive attachments) for 9/12 through 4/13 10. RGSC Monitoring Tools and Summary Reports prepared for SA-PIC meetings (undated) 11. RGSC Monthly Trend Analysis Report 3/31/13 12. RGSC Quarterly Trend Analysis Report 2/28/13 13. RGSC Injury Logs (witnessed and discovered) 9/1/12 to 5/1/13 14. Corrective Action Plan (CAP) Reporting from 9/1/12 to 4/30/13 15. Sample of completed SA monitoring tools 16. Incident Management Review Team (IMRT) minutes for meetings from 9/1/12 to 4/30/13 17. Independent Ombudsman Annual Report for 2012 18. Self-Advocates meeting minutes 6/12 through 3/13 19. Sample of 20 CAPs 20. Sample of completed CAP Audits 21. Sample of CAP Effectiveness Audits **People Interviewed:** 1. Mary Ramos, Quality Management Director 2. Rosie Sanchez, QE Coordinator 3. Alondra Machado, Data Analyst **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 5/15/13 2. Settlement Agreement Performance Improvement Council (SA-PIC) 5/14/13
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section E, in conducting its self-assessment, the Facility: • Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the

	monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included the Statewide DADS tools supplemented with some additional Facility specific tools. o These monitoring/audit tools included indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as observations, interviews, record reviews, and data review. o The Self-Assessment identified, where appropriate**,** the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample sizes were adequate to consider them representative samples. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results although the Facility had not implemented any inter-rater reliability into its QA system. o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically/programmatically competent in the relevant area(s). o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. • Used other relevant data sources and/or key indicators/outcome measures. This was variable and dependent on the data systems that were in place for each section of the SA. • The Facility presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented, for many sections of the SA**,** findings based on specific, measurable indicators. o Measured, for many sections of the SA**,** the quality as well as presence of items. o Distinguished data collected by the QA Department versus the program/discipline. The Facility rated itself as being in compliance with Provision E.2 and E.3 of Section E. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with Provision E.3. With respect to Provision E.2 (data analysis and development of Corrective Action Plans) the Facility had a system for data analysis which resulted in corrective action planning but data was not always delineated in sufficient detail, and the quality of data was variable department to department. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. • Actions were reported as completed, in process, or not started. • The Facility data identified areas of need/improvement. For example, in Provision E.1, 15 action steps were presented. • The actions did provide a set of steps likely to lead to compliance with the requirements of this

	Section.
	Summary of Monitor's Assessment: The Facility had done a number of things since the last review to move closer to compliance with Section E, including 1) updating its Quality Assurance policy and its Improving Organizational Performance Program document, 2) implementing CAP initiation audits, CAP completion audits, and CAP effectiveness audits, and 3) taking action through a CAP reduction initiative to better define circumstances where a CAP is an appropriate mechanism for corrective action planning. On the other hand the implementation of QA processes at the Facility was variable department to department and the Facility needed to develop key indicators from which both processes and outcomes can be measured. The Facility collected data that was 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. The Facility had laid a sound foundation for continued refinement of data tracking required by the SA. The Facility generates a large number of CAPs directed at administrative errors/omissions by individual staff, with the unintended consequence of an overwhelming amount of data. The Facility was engaging in a CAP Reduction Initiative to better define circumstances where a CAP is an appropriate mechanism for corrective action planning. 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. This continues to be the case. CAPs are designated as "high urgency" or "low urgency" which, because of the large number of CAPs can help focus management attention to high urgency issues. The majority of CAPs (including those designated as high urgency) were not completed timely. The Facility had revised its Human Resource policy 100-07 (2/13) to include timely CAP completion as an essential component of employee performance appraisal, including taking adverse administrative action against employees unwilling to cooperate with the CAP implementation process. The data system developed by the Facility is extremely flexible and is being used more for management oversight and performance accountability. Still lacking in the Facility QA process are elements intended to address substantive information regarding clinical outcomes and key indicators. 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. Further, initiating CAP Initiation Audits, CAP Completion Audits, and CAP Effectiveness Audits are positive steps that should lead to compliance in future reviews. As noted in previous reports, 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 used to encourage those reviewing data reports to engage in critical thinking. The Monitoring Team observed continued implementation of this process. As noted in previous reports, 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. There remains a need to present data in more finite detail, for example, 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 where appropriate.

#	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.	State QA policy There was a state policy that adequately addressed all five of the provision items in section E of the Settlement Agreement. There were no changes to the state policy 003.1: Quality Assurance, dated 1/26/12. Positive aspects included: • It seems to have reserved policies for statewide development, and procedures for facility development. This will keep the terminology consistent and the facility should not have to re-label the state policy to adopt it. • It included language for CAPs to both remedy and prevent (reduce recurrence), acknowledging both important roles. • The policy language was simple and straightforward and the bullet style will make it easy for staff to read. • It required disciplines to keep account of their databases and the QA department to keep track of all databases. Other comments: • The policy hinted at addressing both systemic issues and serious individual ones, but stopped short of encouraging the facilities to have procedures to deal with both. • There did not appear to be a list of key indicators or a directive to develop a list. • The tie between QA and the self-assessment was not well described. This could, however, be covered in procedure or in a guideline for the self-assessment. The state policy called for a statewide QA/QI Council and for statewide discipline QA/QI	Noncompliance

#	Provision	Assessment of Status	Compliance
		committees. Neither was in place at this time. Also, given that the statewide policy was disseminated more than a year ago, edits may already be needed. State office should consider this. <u>Facility QA policies and practices</u> The Facility had updated its Quality Assurance policy and its Improving Organizational Performance Program document since the last review. There were facility policies that adequately supported the state policy for quality assurance. The Facility had a Settlement Agreement Performance Improvement Council (SA-PIC) which performed the same functions as the Quality Assurance/Quality Improvement (QA/QI) Council required by State policy. The Facility collected data that was 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. A report submitted to the Monitors noted required use of monitoring tools (the source of much data) was variable by SA section, as low as 30% and as high as 100%. The Facility self-assessment reported similar data. There was a complete and adequate data list/inventory at the facility. The data list/inventory at the facility was current. The QA plan narrative at the Facility was not current and comprehensive. It did not include provisions for inter-rater reliability. The Facility reported it is working to realign QA staff responsibilities to allow some staff time to conduct inter-rater reliability in high risk, high volume, and problem prone areas. The Facility's QA Plan consisted of three documents that have to be reviewed together to get a complete understanding of the QA program in place at the Facility. These were 1) RGSC Quality Assurance Plan, 2) RGSC SOP QM 100.014 Quality Assurance Expectations, and 3) RGSC Improving Organizational Performance. Taken together, the information, process requirements, and QA expectations described included the essential components of a good QA Plan. In the future, the Facility may want to consider consolidating information into one document that would include: • a description of the purpose of the QA program, • the organizational structure of the QA process (including individual roles and responsibilities), • the data list/inventory, • the QA matrix,	

#	Provision	Assessment of Status	Compliance
		• key indicators used at the Facility, • a description of how data are summarized and analyzed, • a description of the role of other clinical and operational departments in QA, • description of workgroups/Performance Improvement Teams, • the QA report, • a description of the SA-PIC and its role in reviewing data and guiding the entire QA process, and • description of the corrective action plan (CAP) process The QA plan matrix contained the data to be submitted to the QA department; these data are then included in QA reports and presented to the QAQI Council. For the 20 sections of the Settlement Agreement, an adequate set of key indicators were included for none of the 20 sections (0%). The Facility reported it is collecting data addressing many subjects (e.g. bowel movements, number/type of restraints, number/type of allegations, medical appointments, hospitalizations, timely completion of assessments, etc.), but there was not enough data collection and analysis (key indicator data) covering enough subject matter to meet the expectations of the Settlement Agreement. The Facility had been reviewing a comprehensive set of key indicators developed in another State and discovered that it already collects, or has the ability to quickly pull data (Crystal Reports) for many of the indicators listed. The Facility reported its goal for the next monitoring visit is to put this information into a monthly trend report for presentation to either SA-PIC or the ICF Integration of Services meeting for review and analysis. The QA plan matrix did include all self-monitoring tools/self-monitoring procedures. All data that QA staff members collect were listed on the matrix. All of the items in the QA plan matrix did also appear in the QA data list/inventory. Of the 102 items in the QA plan matrix, 94 (92%) were submitted/collected/received by the QA department for the last two reporting periods for each item (e.g., monthly, quarterly). The exceptions were for Sections N and Q of the SA. Of the 102 items in the QA plan matrix, 94 (92%) were documented to show review or analysis by the QA department and/or the department section leaders for the last two reporting periods for each item (e.g., monthly, quarterly). The exceptions were for Sections N and Q of the SA.	

#	Provision	Assessment of Status	Compliance
		Of the 102 components of the QA plan narrative and QA plan matrix, the Facility implemented 94 (100%). The exceptions were for Sections N and Q of the SA. Documentation and observation did indicate that QA staff assisted each discipline in analysis of data, or if there was no assistance provided, there was documentation that it was not needed. Of the 17 self-monitoring tools for the SA included in the sample, (a) the content of 17 (100%) appeared to be appropriate and (b) 17 (100%) were reviewed within the past six months, and revised as appropriate. Sections N and Q of the SA did not have Monitoring tools in use. Of the 17 self-monitoring tools for the SA included in the sample, 17 (100%) had adequate instructions for the user. Since the last onsite review, of the self-monitoring tools for the 19 sections of the SA (one is not expected for Section E) 17 (89%) were implemented as per the QA plan (e.g., number, schedule, person responsible). The exceptions were for Sections N and Q of the SA. Since the last onsite review, of the 19 sections of the SA, there was documentation that the implementation (not including inter observer agreement) and results (including outcomes) of self-monitoring were reviewed with the department staff at least once each quarter for 17 (89%) of the 19 sections. The exceptions were for Sections N and Q of the SA. Based on this review the Monitoring Team determined this Provision was not in compliance. This was consistent with the Facility's self-assessment. Implementation of inter-rater reliability is missing from the current QA system. Inter-rater reliability is necessary to ensure validity of data. Additionally, while a good data collection and analysis system is in place the Facility reports that not all required data is regularly reported and compliance expectations are not being sustained over time. The Monitoring Team is hopeful that with the continued maturation of the QA system, and continued vigilance from QA staff, this will improve.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address	All data in QA plan matrix should be summarized, graphed, and analyzed by discipline department with oversight and additional assistance as needed by the QA department. Data from the QA plan matrix for one of the 19 (5%) sections of the SA (not section E)	

#	Provision	Assessment of Status	Compliance
	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.	were appropriately summarized, graphed showing trends over time, and analyzed across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals. This was the case with Section D. The Facility reported that data associated with other sections of the SA did not include the required detail. The Facility reported most of the detailed data can be pulled from its databases which should facilitate a higher degree of compliance in the future. 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. This continued to be the case. Since the last onsite review, a meeting occurred at least twice for 18 of the 18 sampled (100%) sections of the SA. The Facility had 23 committees addressing a variety of topics. Some were specific to the SA but most had been established as part of the Facility's management structure. The QA system relies on these committees to review and assess data reports generated by the QA department. A member of the QA department sits on each committee for the ICF Program as a "quality advisor". The quality advisor works with each team assigned to ensure the required data and information is addressed at the committee. Committees (and meeting schedules) responsible for SA subject matter include: Human Rights Committee (weekly); SA-PIC (bi-monthly); IMRT (daily); Integration of Services (monthly); Provision of Care (monthly); PNMT (weekly); Psychology Peer Review (monthly); Nursing (monthly); Polypharmacy (monthly); Medication Management (monthly); P&T (quarterly); and Safety/Risk Management/Infection Control (monthly). Committees are to review and analyze the items noted on the QA Plan. Business requiring action is kept as an open item on the agenda until the committee feels it has been completed appropriately. Each committee is able to create a CAP to address any areas of their responsibility requiring correction. The QA Department was able to track the number of CAPs by the Committee that assigned the CAP. QA Plan review should include, among other things, the following: • Review of the data listing inventory and matrix, • Discussion of data and outcomes, • Review of the conduct of the self-monitoring tools, • Development of necessary corrective action plans, • Review of previous corrective action plans. The Facility should ensure that the committees referenced above include these topics as	

#	Provision	Assessment of Status	Compliance
		part of their regular agenda. Since the last onsite review, during all (100%) of the meetings, at least some relevant data were available to facilitate department/discipline analysis of data. Since the last onsite review, during all (100%) of the meetings, data were reviewed and analyzed. Since the last onsite review, during all (100%) of the meetings, action plans (and/or CAPs) were created for systemic problems and for individual problems, as identified. Since the last onsite review, a facility QA report (for dissemination at the Facility and for presentation to the SA-PIC) was created for nine of the nine months (100%). Of the 19 sections of the SA, 19 (100%) appeared in a QA report at least once in each quarter since the last onsite review. Even though Sections N and Q did not have monitoring tools, data from other sources were presented. Of the sections of the SA that were presented, one of 19 (5%) contained the following components: o Self-monitoring data ▪ Reported for a rolling 12 months or more (all 19 sections included this) ▪ Broken down by program areas, living units, work shifts, etc., as appropriate (only Section D reported this level of data delineation) o Key indicators ▪ Reported for a rolling 12 months or more (all 19 sections included this) ▪ Broken down by program areas, living units, work shifts, etc., as appropriate(only Section D reported this level of data delineation) o Narrative analysis (all 19 sections included this) There was an adequate description of the SA-PIC in the RGSC policy Quality Assurance Expectations and the RGSC policy Improving Organizational Performance Program. Since the last onsite review, the SA-PIC did meet at least once each month. Minutes from nine of the nine (100%) SA-PIC meetings since the last review indicated that the meeting occurred according to schedule. Minutes from nine of the nine (100%) SA-PIC meetings since the last review indicated that the agenda included relevant and appropriate topics,	

#	Provision	Assessment of Status	Compliance
		Minutes from nine of the nine (100%) SA-PIC meetings since the last review indicated that there was appropriate attendance/representation from all departments. Minutes from nine of the nine (100%) SA-PIC meetings since the last review documented that (a) data from QA plan matrix were presented, (b) the data presented were trended over time, (c) comments/interpretation/analysis of data were presented. In nine of the nine meetings (100%), recommendations and action plans were developed when appropriate to do so, and were based on the data presented. During a SA-PIC meeting observed by the Monitoring Team, there was active participation of participants other than the presenter for eight of the 13 (62%) of reports/data presented during the meeting. This was appropriate. The other five reports were intended to share information rather than generate problem-solving discussion. An adequate written description did exist that indicated how CAPs are generated, including the criteria for the development of a CAP. The Facility generates a large number of CAPs directed at administrative errors/omissions by a particular staff person. The Facility was engaging in a CAP Reduction Initiative to better define the types of circumstances where a CAP is an appropriate mechanism for corrective action planning. When considering the full set of CAPs, they did appear to have been chosen following the written description in policy or procedure, although as noted above a project was underway to provide better criteria for problems/issues requiring a CAP. Of the 20 CAPs reviewed by the Monitoring Team, 20 (100%) appeared to appropriately address the specific problem for which they were created. These included CAPs identified as addressing systemic issues and non-systemic issues. Based on a sample of 20 CAPs: 1. 20 (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. 2. 20 (100%) included the anticipated outcome of each action step (many CAPs had only one action step, for example, retraining a specific employee). 3. 20 (100%) included the person(s) responsible for implementation. 4. 20 (100%) included the time frame in which each action step must occur. The tracking of CAPs at the Facility is well designed and flexible. At the time of CAP initiation, each CAP was designated as "high urgency" or "low urgency." High urgency CAPs are to be implemented within one week. Low urgency CAPs are to be implemented within two weeks. CAPs are coded in such a way that reports can be prepared and used	

#	Provision	Assessment of Status	Compliance
		for managerial oversight and accountability. For example, CAP reports can be prepared that display: 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. 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. 3. High urgency open CAPs whose completion is delinquent by more than 30 days (or any other time oriented variable). 4. Low urgency open CAPs whose completion is delinquent by more than 30 days (or any other time oriented variable). 5. CAPs developed to address systemic issues. The data system developed by the Facility is extremely flexible and its use should be very useful for management oversight and performance accountability. Based on this review the Monitoring Team determined this Provision was not in compliance. This was not consistent with the Facility's self-assessment. While the Facility had a defined system for data analysis, which resulted in corrective action planning, data was not always available or delineated in sufficient detail, and the quality of data is variable department to department.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a sample of 20 CAPs, all 20 (100%) included documentation about how the CAP was disseminated; all 20 (100%) included documentation of when each CAP was disseminated, and; all 20 (100%) included documentation of to whom it was disseminated, including specific person(s) responsible. The Facility maintained a CAP Initiation Audit process to support compliance with this Provision. This ensured review of at least 10 CAPs per month. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	Substantial Compliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	Based on a sample of 20 completed CAPs, 20 (100%) were implemented fully and five (25%) were implemented in a timely manner. The Facility acknowledged that timely CAP completion is a problem which is subject to monthly auditing. In its self-assessment the Facility reported compliance rates (meaning CAPs that were completed within the specified timeframe) ranging from 10% to 60%. The majority of CAPs (including many designated as high urgency) were not completed timely. This is in effect evidence that those CAPs, based on timeliness alone, did not meet their desired outcome. With respect to determining whether or not a CAP remedied or reduced the problem originally	Noncompliance

#	Provision	Assessment of Status	Compliance
		identified, the Facility had initiated CAP Effectiveness Audits. In its self-assessment the Facility reported it had determined that 88% of abuse/neglect CAPS were effective and 93% of systemic CAPs were effective. The Monitoring Team did not independently verify these data. The data system developed by the Facility is extremely flexible and is being used more for management oversight and performance accountability. The Facility had revised its Human Resource policy 100-07 (2/13) to include timely CAP completion as an essential component of employee performance appraisal, including taking adverse administrative action against employees unwilling to cooperate with the CAP implementation process. As reported in Provision E.2, the CAP tracking system can produce reports that delineate late implementation sorted by employee. 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. Further, initiating CAP Initiation Audits, CAP Completion Audits, and CAP Effectiveness Audits are positive steps that should lead to compliance in future reviews. There was an adequate system for tracking the status of CAPs. This included regular review at IMRT meetings which occurred daily and SA-PIC meetings which occurred monthly. This review activity was documented in meeting minutes. The facility QA director (a) did maintain summary information/data regarding CAPs and their status that was updated within the month prior to the onsite review and (b) did present this information to QAQI Council at least quarterly. As noted in the last review, 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. Based on this review the Monitoring Team determined this Provision was not in compliance. This was consistent with the Facility's self-assessment.	
E5	Modify corrective action plans, as necessary, to ensure their	The Facility had initiated a process for CAP Effectiveness Audits. At the time of this review this process was directed primarily at Section D of the SA because most CAPs that	Noncompliance

#	Provision	Assessment of Status	Compliance
	effectiveness.	had been developed and completed were related to incident management. The Facility produced three examples of CAPs that had been reviewed by the SA-PIC and for which modification was necessary. One review concluded that a CAP required training of staff had not occurred, one concluded that some support materials for an Individual had not as yet been provided, and one concluded that staff doing rounds was not following CAP-required protocol. This was a very small percentage of CAPs initiated by the Facility. The Facility management system for monitoring CAP implementation and modifying CAPs as necessary had started to produce limited data as to the effectiveness of the management system. This system needs to expand to all sections of the SA and at least in the early stages focus on systemic and high urgency CAPs to ensure the management effort is directed at high risk, high volume, and problem prone areas. Particular attention should be paid to the timeliness of CAP completion in assessing the effectiveness of modified CAPs, especially with high urgency and systemic CAPs. Based on this review the Monitoring Team determined this Provision was not in compliance. This was consistent with the Facility's self-assessment.	

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

1. Continue and evaluate effectiveness of implementation of management control procedures for CAP implementation and hold those responsible for CAP implementation accountable for all sections of the SA (Provisions E.2, E.3, E.4, and E.5).
2. Develop key indicators and use data associated with them to assess organizational performance for all sections of the SA (Provisions E.2, E.3, E.4, and E.5).
3. Further delineate data items to be collected in all sections of the SA where appropriate 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 (Provision E.1).
4. Develop a system for inter-rater reliability of monitoring/auditing results (Provision E.1).
5. 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:** **Documents Reviewed:** 1. RGSC Self-Assessment 4/29/13 2. RGSC Action Plan 4/25/13 3. RGSC Section F Presentation Book 4. DADS Policy 004.1 Individual Support Plan Process and attachments (11/20/12) 5. RGSC Standard Operating Procedure (SOP) ICF-IID 600-01 Individual Support Plan Process (August 2012) 6. Individual Support Plans (ISPs) and Supporting Documentation for Individuals #29, #47, #79, and #101. Documentation requested included: a. The full ISP document, b. All assessments considered during that ISP development process, c. The Personal Focus Assessment, d. MRA CLOIP Assessment Worksheet or most recent Permanency Plan, e. Sign in sheets showing IDT members attending the ISP meeting, f. Any ISP addendums, g. All associated skill acquisition/teaching programs, h. Completed Rights Assessment, and i. Completed Decision-Making Functional Capacity Assessment. j. The last three monthly reviews; k. The last two quarterly reviews; l. Individual's daily schedule; m. Special Considerations list; and n. Third quarterly meeting documentation. 7. An alphabetical list of each individual at the Facility, with the most recent ISP meeting date, the date on which the ISP document was completed/filed, and the date of the previous ISP meeting date 8. ISP assessments tracking log monthly report September 2012-March 2013 9. List by discipline of annual assessments filed within 10 days for annual meeting dates of 4/4/12-3/31/13 10. Assessment Filing-Number of Times filed later than 10 days for meetings between the dates of 4/4/12 and 3/31/13 11. Printout of posted assessments for Individual #118 12. Active Record for Individual #115 13. ISP attendance tracking log by discipline 9/1/12-3/31/12 14. Last ten Quality Assurance monitoring tools for Section F audits undated 15. In response to a document request for tools used to measure QDDP competency with regard to facilitation of ISP meetings and writing of ISP documents, the training materials provided by the Facility

	16. QDDP Caseloads 5/10/13 17. Nine Section F monitoring tools (undated, except for one with an ISP date of 2/5/13 18. PBSP Competency Assessment Log **People Interviewed:** 1. Joint Interview Juan Miguel Gonzalez (Program Improvement Coordinator), George Romero (QDDP Manager), Rosa Sanchez (Quality Assurance Director), and QDDPs Karina Serratos, Rebecca Olivarez, Daniel Perez **Meetings Attended/Observations:** 1. ISP Annual Planning Meetings for Individuals #118 and #134 2. Pre-ISP Planning Meeting for Individual #48
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section F, in conducting its self-assessment, the Facility: ▪ Used relevant data sources and/or key indicators/outcome measures. Data covered a wide range of issues such as attendance at ISP annual planning meetings, timeliness of assessments, whether preferences/strengths/needs were addressed in ISPs, inclusions in ISPs of "recommendations in regards to ability to live in a most integrated setting," whether ISPs provide meaningful opportunities to develop new skills and increase opportunities for community integration, whether ISPs include actions/SAPs that encourage community participation, whether goals are observable and measurable, and whether monthly reviews by QDDPs were completed as required, among many others. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Presented findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. For example, the presence in ISPs of preferences and strengths was reported, but there was no comment on whether these lists of preferences and strengths were accurate, how they were identified, or whether the preferences and strengths listed were ones that would affect decisions about services, supports, and interventions. o Identified levels of compliance that were, in some cases, consistent with the findings of the Monitoring Team but in other cases were inconsistent with the findings of the Monitoring Team. For example, data on whether ISPs address recommendations about most integrated setting were consistent with findings of the Monitoring Team. Ratings about meaningful opportunities to develop new skills and increase opportunities for community integration were inconsistent with findings of the Monitoring Team. The Facility should review the report to identify areas in which there are inconsistencies; such review should lead both to redefining the criteria for the self-assessment ratings and to ensuring provision of additional confirming information to the Monitoring Team in future visits.

	▪ The Facility rated itself as being in compliance with Provisions F1d, F1e, F2a3, and F2a5. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with no following provisions. o Regarding Provision F1d, the self-assessment determined substantial compliance based on a review of eight ISPs that reflected that recommendations are addressed in the ISP and that ISPs used assessments to develop action plans. The self- assessment rating did not address the data showing only 57% of monthly reviews were completed (which is understandable, as that related more closely to a different provision). However, the Monitoring Team found noncompliance because observation of two ISP annual planning meeting showed that use of assessments to develop action plans was inconsistent, and noted that skill acquisition plans were not consistently based on assessments. o Regarding Provision F1e, the self-assessment determined substantial compliance based on recommendations for most integrated setting being included in ISPs, and also provision of meaningful opportunities to develop new skill and increase opportunities for community integration. However, the Monitoring Team determined that lack of timely assessments and a focus on the supports provided in the Facility rather than those that would be needed for community living meant the Facility had not yet achieved substantial compliance, although significant improvement had occurred. o Regarding Provision F2a3, the self-assessment found that goals and objectives in the PNMP, PBSP, IHCPs and Nursing Care Plans are integrated into the ISP. The Monitoring Team found this had improved but remained inconsistent. o Regarding Provision F2a5, the self-assessment rated substantial compliance because ISPs had adequate interventions and strategies that target practical and function outcomes. The Monitoring Team found little rationale for the functionality of selected goals for individuals, and a lack of goals for learning in communities within the sample reviewed. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as complete, in process, or not started. ▪ The Facility data identified areas of need/improvement. However, most of the actions were activities that would need to be ongoing rather than steps that are needed to ensure those activities are implemented and are of high quality. For example, one action for Provision F1c is to "Include completion of the PSI in the Pre-Planning Staff meeting, which specifies the preferences, strengths and weaknesses of the Individual served." This will need to be an ongoing practice, given the current ISP process. The action plan should state what activities will be implemented in order to achieve this, and what activities (such as refresher training or monitoring) will be implemented to maintain it. ▪ Although improvement will be needed in specifying actions to be implemented, the actions provided a set of steps likely to lead to compliance with the requirements of this Section.
	Summary of Monitor's Assessment: RGSC had just recently received training and initiated the revised ISP process. Certain steps in the process,

	such as the pre-ISP meeting, are just being initiated. Nevertheless, the Facility continues to make progress in a number of areas, although it has not achieved substantial compliance yet for any provision. The interdisciplinary teams are facilitated by QDDPs who have completed competency-based training. Compliance will require that they are able to ensure assessments are completed timely, and that information from assessments is used consistently in decision-making. Several disciplines had participated regularly in ISP annual planning meetings, but for others, participation was not consistent. Clear listings of which disciplines are required to participate will provide guidance, but the decisions on who is required should be made based on the preferences and needs of the individuals, not on what practice is routine or on the availability of resources. A significant problem that affected the potential for compliance with several provisions was the lack of timely completion of assessments. For assessments to be useful, they must be available to all IDT members in time for them to be reviewed prior to meetings. There was improvement in completion of assessments in response to changes in status, but further improvement is needed. Living Options Discussions at the ISP annual planning meetings observed were substantive. However, due in part to the lack of completed assessment, there was no evidence that the Facility had improved in identifying the supports, services, and protections that would be needed in a more integrated setting or in focusing more on the services and supports that would be needed for community living when developing action plans and goals. Although ISPs listed preferences and strengths, it was unclear for each of those how this information was translated and prioritized from the PSI to the decision-making on supports needed or on encouragement of community participation as reflected in the ISP. In contrast to the findings of the self-assessment, the Monitoring Team found ISPs did not provide adequate strategies to encourage meaningful community participation. Although the observed ISP annual planning meetings and the ISP Planning meeting demonstrated interdisciplinary and integrated discussion, there was little evidence in the ISPs themselves that such a unified approach was in place. ISP annual planning meetings were held timely. However, the resulting ISP revisions were not completed timely.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of	Since the Monitoring Team's last review, DADS had issued Policy #004.1: Individual Support Plan Process, dated 11/20/12. RGSC SOP 600-01, revised August 2012 guided	

#	Provision	Assessment of Status	Compliance
	the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	the individual support planning process at the Facility. Although similar in most respects, this policy did not fully match the requirements of DADS policy. This policy was due for review in April 2012. To assess compliance with the requirements of Provision F1, the Monitoring Team reviewed facility and DADS policy, ISP tracking and attendance tracking logs, data summaries on assessments completed and on team member participation in annual ISP meetings, information gathered about participation by specific disciplines and reported in other Sections of this report, and Individual Support Plans (ISPs) and Supporting Documentation for Individuals #29, #47, #79, and #101. The Monitoring Team interviewed QDDPs and the QDDP Manager and observed annual ISP planning meetings for Individuals #118 and #134, and the pre-ISP planning meeting for Individual #48. Although DADS has requested that review of ISPs focus on those that followed the new process, the Monitoring Team had to review samples of recent ISPs that did not yet fully implement the new process during this visit. Because of the recent implementation of the new process, even recent ISPs did not include all aspects, in particular the ISP Preparation meeting that occurs ninety days prior to the annual ISP meeting.	
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. This produced caseloads of 15-17 individuals, a reasonable number. According to the Self-Assessment, two of four QDDPs (50%) had completed facilitation training—the Q Construction: Facilitating for Success training, which included a competency-based component. However, the QDDP Manager, in interview, reported that all four QDDPs (100%) were certified at the time of the visit. He reported that annual competency checks had been done for certified QDDPs and two new QDDPs had been certified. In response to a request for tools used to measure competency, the Facility provided a set of training materials for QDDP training and Supporting Visions training. These materials did include exercises and activities; however, they did not include tools to measure competency. Observation at two annual ISP planning meetings confirmed that the QDDP was the team leader responsible for ensuring team participation. The QDDP and other IDT members encouraged individuals to participate. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		treatments, services, and supports as needed as described below under Provisions F2a6 and F2d. <u>Conclusion</u> Although the Interdisciplinary Team (IDT) was facilitated by one person from the team (the QDDP), the QDDP did not consistently ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	
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> The Facility tracked the attendance of IDT members at annual ISP meetings. The self-assessment reported these data for eight sampled ISP meetings from 9/1/12 through 3/31/13 and found that 88% of required IDT members were present, the individual was present at 63% of the meetings, and the LAR was present and/or available via telephone at 100% of the meetings. The Monthly Attendance by Discipline report for 9/1/12-3/31/13 documented a range of attendance by discipline ranging from 0% (for Active Treatment staff—zero of one required meeting) and 12% for physicians to 100% for several disciplines. The Monitoring Team reviewed recent ISPs for Individuals #29, #47, #79, and #101 to determine attendance at each of the annual planning meetings. No information was requested or provided regarding which disciplines were required for each of these four meetings. Sign-in sheets indicated the following for the four meetings: • The QDDP was present at four (100%). • The Individual was present at one (25%). • The LAR or correspondent/family member was present at zero (0%). This was inconsistent with the monthly attendance by discipline report, which reported 86% for family and 67% for LAR; however, family was only required for seven meetings, and LAR was only required for 9 meetings, so this discrepancy may result from the sample selected. • A direct support professional (DSP) was present at three (75%). • For other disciplines, the number present ranged from four to eight. Disciplines present at 100% of meetings were nursing and vocational services; disciplines present at 25% or less of the meetings included primary care provider (PCP), dental services, occupational therapist/physical therapist (OT/PT), and pharmacy services. This was relatively consistent with the percentages reported for most disciplines on the monthly attendance by discipline report, except that report showed 57% for PT and 69% for OT, and 100% for psychology assistant. • The Local Authority (LA) was present at four (100%).	Noncompliance

#	Provision	Assessment of Status	Compliance
		As noted in other Sections of this report, review of specific disciplines noted the following: • As reported in Provision L1, review of ten ISPAs (Individuals #72, #4, #85, #93, #143, #126, #29, #19, #21, and #5) indicated that the primary care physician participated at zero out of ten ISP meetings (0%). • As reported in Provision O3 for a sample of individuals with PNMPs, all annual ISPs reviewed documented at a minimum an Occupational (OT) or Physical Therapist (PT) as well as Speech Therapist (SLP) present to discuss the PNMP. • As reported in Provision P2, ten of 10 ISP annual meetings (100%) had a member from either OT or PT present to represent the disciplines. • As reported in Provision R3, based on review of the ISPs for individuals in Sample R.1 and R.3, in seven of 14 ISPs reviewed (50%) for individuals with communication needs an SLP attended the annual ISP planning meeting, or the team provided adequate justification as to why the SLP was not needed. The Monitoring Team observed at the ISP annual planning meetings for Individuals #118 and #134. • For Individual #134, the Monitoring Team requested but did not receive the sign-in sheet. Based on observation, at a minimum the individual, QDDP, psychiatrist, nurse, DSP, vocational staff, and local authority were present. The physician was not present; neither was family. • For Individual #118, the Monitoring Team did not request or receive the sign-in sheet. Based on observation, at a minimum, the individual, QDDP, nurse, psychology assistant, and local authority, among others. The physician and family were not present. Per the ISP Preparation Meeting listing of IDT members required for the annual ISP meeting, the physician was not required; without the sign-in list, it is not possible to verify that all required members were in attendance, but it appeared likely they were. The recently implemented ISP preparation meeting will identify disciplines required to be present. Review of that document will make clearer whether required IDT members participate. The Monitoring Team observed the pre-ISP planning meeting for Individual #48. A list was developed at that meeting of who would need to attend the ISP annual planning meeting. <u>Extent of Individual participation in ISP:</u> The individuals attended both ISP meetings. At both, there was active involvement of the individual, and the QDDP and other IDT members attempted to learn the individual's preferences. At the meeting for Individual #134, the IDT listened to those preferences on	

#	Provision	Assessment of Status	Compliance
		issues such as movement to a more integrated setting and decisions on medical care, and responded according to those preferences. <u>Conclusion</u> Attendance, while improved, still needs additional consistency. If the physician cannot attend, there is a need for documentation of how the physician's information becomes part of the meeting, and of how the physician may respond to information provided at the meeting. As noted above, the pre-ISP planning meeting should provide clarity of who is required to attend.	
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> DADS Policy 004.1 continued the requirement that IDT members complete required assessments and place them in the shared drive for IDT review no later than 10 working days before the annual ISP meeting. RGSC SOP ICF-IID 600-01 had the same requirement. The Facility must ensure its policies meet the standards required by statewide policies. The processes at the Facility to implement the statewide policy and processes were still in early stages, being implemented as ISP annual planning meetings were scheduled. The Facility provided an ISP assessments tracking log monthly report for ISPs from September 2012-March 2013. The tracking log provided the percent of assessments completed and the percent timely by department each month. Percentages of timely completion ranged from 15% in February 2013 to 32% in November 2013. As another check on current status of assessments, the Monitoring Team asked a QDDP to look on the Share Drive for an individual who had an ISP annual planning meeting scheduled within 10 business days. The QDDP selected Individual #118, whose meeting was to be held the next day. Several assessments were not yet posted. The Monitoring Team requested a printout of the assessment report for this individual. Review of the printout found the following: • Of 21 assessments due, 17 (81%) were completed by the due date 10 days prior to the ISP annual planning meeting. This was significantly higher than the timeliness data from the assessments tracking log. • Assessments not completed timely were the Medical Assessment, Dental Assessment, Rights Assessment, and Water Safety Assessment. Similar levels of timely completion of assessments were found in samples of documentation reviewed for other provisions of the Settlement Agreement. • As reported in Provision P1, two of 10 individuals' OT/PT assessments in sample P.1 (20%) were dated as having been completed at least 10 days prior to the annual ISP.	Noncompliance

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		• As reported in Provision M3, four of nine (44%) nursing assessments provided for review were not current, one individual's annual assessment was over a year old and three individuals' did not have the last quarterly nursing assessments completed for the past two to three quarters. • As reported in Provision Q1, dental evaluations were not consistently provided. The Facility provided nine monitoring tool audits of ISP. There were numerous areas in which the Monitoring Team findings were inconsistent with the findings of these audits. These will not be detailed in the report. However, one example is that of comprehensive assessments. The audits uniformly found that comprehensive assessments were routinely conducted and used to identify strengths, preferences, and needs. As the data above demonstrate, most assessments were not even completed in time for review by other IDT members prior to the ISP annual planning meeting. <u>Timeliness of assessments for newly admitted individuals</u> Through computer randomization, the Monitoring Team selected Individual #115 to review timeliness of assessments; review took place 5/15/13. This individual was admitted in March 2013. Of 13 assessments that should have been completed within 30 days, seven (54%) had been completed timely. One additional assessment had been completed within the prior week, well over the 30-day timeline. Furthermore, as reported in Provision K7, based upon tracking data provided by the Facility, two individuals had been admitted to RGSC since the previous site visit. Records reflected that neither of these individuals (0%) had been provided a Psychological Assessment within 30 days of admission. Tracking data reflected that neither individual (0%) had been provided a Psychological Assessment since their admission. <u>Extent to which assessments are conducted in response to significant changes:</u> There was improvement in conducting assessments in response to significant changes, but there remained instances in which assessments were not updated when the need arose. For example: • As reported in Provision L1, there was improvement in post-hospital follow up by medical providers. However, there were cases of dehydration diagnosed by the hospital but not mentioned in the post-discharge follow note. • As reported in Provision L1, quarterly medical assessments were not documented for individuals with chronic conditions. • As reported in Provision L1, for one individual who had a diagnosis of malignancy, triage was timely and clinically appropriate, and initial and follow-up assessments for pneumonia were carried out by the physician. • As reported in Provision O2, individuals were appropriately referred to the	

#	Provision	Assessment of Status	Compliance
		Physical and Nutritional Management Team (PNMT) when they experienced a change in status. However, the Monitoring Team was unable to determine if PNMT assessments were initiated timely, as the evaluation did not provide a clear referral date, nor was the Monitoring Team able to determine if PNMT assessments were completed timely, again due to lack of date of referral and initiation of the assessment. • As reported in Provision P2, OT/PT assessments were not consistently completed in response to a change in status. However, two of two individuals (100%) identified with therapy needs received a comprehensive OT/PT assessment within 30 days of identification. <u>Extent to which assessments are of sufficient quality to reliably identify the individual's strengths, preferences and needs:</u> Quality of assessments continued to improve in general, but there were areas in which assessments were not of sufficient quality. • As reported in Provision K5, the quality of Structural and Functional Assessments remained relatively high, although there might have been some decline. • As reported in Provision M2, review of nursing assessments indicated nursing assessments did not include all requirements monitored through a standard monitoring tool. • As reported in Provision Q1, the ISP of zero out of nine (0%) cases adequately documented the individual's oral health condition, prognosis of oral health issues, how the individual's oral health condition affects the individual, and all necessary supports and services for the management of oral health issues; however, the ISP for Individual #31 did provide a more comprehensive review of oral health care issues, when compared to other ISPs. • As reported in Provision R2, communication assessments consistently included many, but not all, requirements of a comprehensive assessment. • As reported in Provision S1, based upon all SAPs reviewed, there was little indication that the Facility had provided adequate assessment in relation to skill acquisition training. The Monitoring Team found an additional limitation in the process for assessing capacity for decision-making. As reported in Provision U1, the Facility did not routinely use standardized or valid instruments and/or processes to assess functional decisional capacity. The Facility is making efforts to address this concern.	
F1d	Ensure assessment results are used to develop, implement, and revise	<u>Extent to which assessment results are used to develop ISPs:</u> 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. Observation of the ISP annual planning meetings for Individuals #118 and #134, and the pre-ISP meeting for Individual #48, showed examples of both use of information from assessments and lack of use of such information. • At the ISP meeting for Individual #134 on 5/14/2013, a primary care physician was not present for the meeting; however, healthcare issues were represented by a nurse. The contract psychiatrist addressed psychiatric issues, and psychotropic medications. Although information from assessments was referenced during these meetings, the following examples identify situations in which the IDT could have used such information to make more informed decisions. • For Individual #134, there was discussion of money management; during the meeting, the IDT tested his ability to count coins, rather than first see what the Functional Skills Assessment (FSA) reported. There was no discussion of referring to the FSA to determine what skills the individual demonstrated and what would be an appropriate next step in teaching new skills. • For Individual #118, the only discussion of how skill acquisition programs (SAPs) could be selected that will assist in community living related to self-administration of medication (SAM). No assessment information was discussed when identifying a skill to be trained. A communication skill—push a button when he gets to the medication pass area—was selected without reference to current communication skills or to assessment of the environment to which he might move to determine whether this skill would be useful. As reported in Provision S1, based upon a sample of SAPs reviewed, there was little indication that the Facility had provided adequate assessment in relation to skill acquisition training. There were indications that some disciplines were achieving at least limited success at basing SAPs upon assessments. Although not approaching the level required for substantial compliance, the SLP SAPs at times were based upon adequate assessment.	
F1e	Develop each ISP in accordance with the Americans with	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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).	individual (or LAR) specifically objects. The IDT as a whole and the members individually serve as the state's qualified professionals for this purpose. Each IDT member completing an assessment 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. A Living Options discussion is held during the annual ISP planning meeting, This discussion is intended to result in a decision on whether to seek a more integrated setting or take action to overcome obstacles to such movement. The Monitoring Team attended two ISP annual planning meetings (Individuals #118 and #134) and reviewed four recent ISPs (Individuals #29, #47, #79, and #101) to assess how this process may have affected the IDTs' implementation of this requirement of the SA. At both ISP meetings, there was substantive discussion of the appropriateness of moving to a more integrated setting, and of the individual's interest and preferences. • Facility IDT members stated movement to a more integrated setting was appropriate for Individual #134. The individual was reluctant and described a prior situation. The individual had toured a small number of group homes the prior year, according to the Local Authority and vocational staff. The IDT determined the individual should not yet be referred but an action plan to tour more homes should be developed. There was no discussion of establishing supports and services, including SAPs, that would promote the likelihood of successful movement. • For Individual #118, there was also a substantive discussion, including questions to the individual. Recommendations for supports were discussed. A plan for tours was agreed to. In addition, although there was discussion of SAPs for community living, the IDT agreed on a plan to provide a support service for community visit. There was little discussion of how to pick SAPs that will assist in successful living in a more integrated environment. As noted in Provision F1d, one SAM goal was decided on that was not based on assessing the requirements of homes to which the individual might move. ISPs reviewed for Individuals #29, #47, #79, and #101 showed: • For Individual #29, one of two assessments provided for the documents request (50%) included a determination of the most integrated appropriate setting. • For Individual #47, four of six assessments provided for the documents request (67%) included a determination of the most integrated appropriate setting. One additional assessment included a list of communication and swallowing	

#	Provision	Assessment of Status	Compliance
		supports that would be needed if the individual moved but not a determination of the most integrated setting at this time. • For Individual #79, one of three assessments provided for the documents request (33%) included a determination of the most integrated appropriate setting. • For Individual #101, two of six assessments provided for the documents request (33%) included a determination of the most integrated appropriate setting. An example of providing these determinations and information on support needs was described in Provision P1. • Ten of 10 individuals' OT/PT assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This information was much improved as more detailed requirements were now included as part of the overall determination. • Seven of 10 assessments (70%) provided a statement regarding "Factors for Community Placement" that is detailed and lays out the supportive services needed for successful living. Due in part to the lack of completed assessment, there was no evidence that the Facility had improved in identifying the supports, services, and protections that would be needed in a more integrated setting. Identification of action plans at the observed meeting, and goals established in the ISPs reviewed, demonstrated a tendency to focus primarily on the supports and services currently being provided at the Facility. While such an array may include many essential services and supports, it does not take into adequate consideration the varied needs that may be needed for successful transition and community living. The IDT must identify the supports, services and protections that would be needed in that setting even if the IDT ultimately chooses not to make a referral. The process of identifying the needed supports and services is integral to determining whether a setting would be appropriate, and also serves to assist the individual and LAR to visualize how community living could be safely supported.	
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		

#	Provision	Assessment of Status	Compliance
	years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	<u>Extent to which ISP builds on the individual's preferences and strengths and prioritized needs:</u> The ISP process relied on the Preferences and Strengths Inventory (PSI) to identify personal preferences, strength, and needs. DADS Policy 004.1 requires the PSI to be completed at time of admission and to be reviewed at the ISP Preparation meeting to occur ninety days prior to the annual ISP meeting. Instructions for completion of the PSI state that it "should be updated on a continuous basis throughout the year as new or changing information is learned." Policy 004.1 states that the "preferences, strengths, needs, and personal goals identified in the Preferences and Strengths Inventory guide the integrated discussion." Furthermore, information from the PSI is to guide the IDT in identifying an optimistic vision of the preferred living environment. The PSI covers numerous areas of life including living options, leisure, relationships, independence, and goals, and asks for completion of many items for each area. The PSI has a column headed "How do You Know? Describe how the resident communicated the preference." The instructions do not require or recommend the use of any structured or formal assessment to determine preferences and strengths. Review of PSIs provided by the Facility as part of the ISP packets for Individuals #29, #47, #79, and #101 found: • PSIs were provided for Individuals #29, #47, and #101 • For two out of three individuals (67%), some comments were made in the column indicating "How do you know?" However, in 0 of 2 of those (0%), there were comments that indicated actual evidence. Instead, all comments simply repeated information from the response to the question in a form such as, for a listed preference of liking routine, "(Individual) likes to keep to a routine" or, for a listed strength of adjusts well to change, "Adjusts well to change." Thus, the listed preference or strength and the way the IDT knows it is a preference or strength were typically identical. The Facility must ensure there is some justification and rationale for listed preferences and strengths to ensure they are accurate reflections of the individual's true preferences and strengths. Although four of four ISPs (100%) listed preferences and strengths, it was unclear for each of those how this information was translated and prioritized from the PSI to the decision-making on supports needed or on encouragement of community participation as reflected in the ISP. For example: • For Individual #101, preferences listed in the PSI included that he would like to	Noncompliance

#	Provision	Assessment of Status	Compliance
		live "in a spacious environment," likes to eat at restaurants and walk in the park, likes outings, and likes sweets and cookies. The ISP listed cookies and outings but not spacious environment or walks as preferences. The only relevant action plan was a money management program for inserting money in "the vending machine," which might be considered useful for outings. The living options discussion did not reference the individual's preference for a spacious environment or a place where he could enjoy walks. • For Individual #47, preferences listed in the PSI included liking to walk, liking the park, and a preference for shredding as a vocational activity. The preferences listed in the ISP included shredding and "likes outings" but did not include walking and the park. The living options discussion did state that the individual goes on outings to the mall and park but did not identify that as a specific support that would be needed in a more integrated setting. The only action plan that addressed preferences listed in the ISP was a vocational program for shredding. <u>Extent to which ISP provides an explanation for any need or barrier that is not addressed:</u> IDTs did not consistently provide an explanation for any need or barrier that was not addressed. In none of four (0%) recent ISPs reviewed were barriers clearly identified and addressed, as further detailed in Provision T1b1. <u>Extent to which ISP encourages community participation:</u> The Monitoring Team found that ISPs did not provide adequate strategies to encourage meaningful community participation. Zero of four ISPs reviewed (0%) included a skill acquisition plan (SAP) that provided adequate opportunities for implementation in community settings. Only Individual #79 had a measurable objective for community participation. As reported in Provision S3(b), the Facility reported that 39 individuals had been provided a total of 45 SAPs that were to be implemented in the community. Most of these targeted money management, with the remainder targeting general exposure to the community, communication, exiting a vehicle, using a seatbelt, crossing the street, and physical fitness. Presumably, the program in the ISP for Individual #79 was one of those. For this individual, the ISP included an action plan to purchase items while on community outings. For the prior year, the individual had the same SAP and a second SAP to purchase juice while on a community outing; it was unclear how the Facility reconciled the two overlapping SAPs. Furthermore, money management was not listed as an obstacle to movement to a more integrated setting; instead, anxiety about the move was the obstacle, and this was not addressed in the ISP by any action other than tours to group homes.	

#	Provision	Assessment of Status	Compliance
		IDTs should develop an individualized community participation strategy for each individual that takes in to account their specific learning needs and the obstacles to movement identified in their ISPs. These plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or maintaining relationships with people living and working in the community; and other approaches the Facility might explore and create. All of these provide opportunities for increasing awareness of community living and increasing comfort in new situations, and should be considered in developing an integrated and individualized strategy for each individual.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	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: As reported in Provisions F1e and F2a1, the ISPs reviewed did not include goals that addressed many preferences or prioritized needs. Identified barriers to living in the most integrated appropriate setting were minimal and not addressed by skill acquisition or other strategies beyond tours to group homes. The Facility provided SAPS for Individuals #79 and #101. The SAPS that were provided did not consistently clarify either the strategies or the preferences or needs they addressed. • While some were clearly related to a need, even these were not consistently included in the ISP action plans (for example, a toothbrushing program for individual #79). For others, the relationship to preferences and for how they would overcome identified barriers to living in the most integrated appropriate setting were not made clear. For example, an objective was established for Individual #79 to tolerate the Wilbarger brushing program to reduce sensory and tactile defensiveness. Not only was this not in the ISP action plan, but the ISP did not document any concern with tactile defensiveness. The ISP did document concern with anxiety over tours to group homes, but the program did not reference that as a justification. • For Individual #101, however, an objective for shredding as a vocational activity was directly related to an identified preference for that task. There was no preference or obstacle to movement, however, for a goal to toss a ball to staff. Extent to which ISP identifies 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: As reported in Provisions F1e and T1b1, barriers to movement were identified as anxiety	Noncompliance

#	Provision	Assessment of Status	Compliance
		for Individual #79 and medical issues for Individual #29. In neither case was a measurable objective established in an action plan. 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. As a result, SAPs were not tailored to the unique learning needs, current skills, or physical condition of each person.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	<u>Extent to which ISP integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions:</u> This provision requires that all protections, services and supports, treatment plans, clinical care plans, and other interventions are delivered in a manner that forms a unified approach to meeting an individual's needs and supporting his/her aspirations and preferences. In such an approach, one would expect to see, for example, training in independent living skills to also have components that might include communication skills development, strategies for use of the skills in community settings, incorporation of positive behavior support techniques, and inclusion of or consistency with risk action plans. Although discussion at the observed ISP annual planning meetings and the ISP Planning meeting demonstrated interdisciplinary and integrated discussion, there was little evidence in the ISPs themselves that such a unified approach was in place. Action plans addressed specific goals but showed no relationship to each other. For example: • As noted above, the barrier to movement identified for Individual #79 was anxiety about tours. A SAP was in place for this individual to tolerate Wilbarger brushing to "reduce sensory and tactile defensiveness." There was no indication that this procedure also might be used as a strategy to reduce anxiety prior to or while going on a tour. On a positive note, SAPs for toothbrushing and toileting did not include physical prompting, indicating the IDT may have identified tactile defensiveness as a concern. • Individual #29 was noted in the ISP as having had a diagnosis of arthritic changes to his hip and spine, and has been having problems walking. One action plan goal was to ride an exercise bike. There was no indication that there was review of this in light of arthritic changes, and whether this exercise would be integrated with treatment for arthritis or would be in conflict with such treatment. The ISP also reported that the individual did not have an integrated	Noncompliance

#	Provision	Assessment of Status	Compliance
		health care plan for pain. To ascertain whether protections, services and supports, and interventions were integrated, the Monitoring Team reviewed the ISPs for Individuals #29, #47, #79, and #101. For zero of four (0%), integration was indicated. For example: • For Individual #79, there were two separate community purchase objectives that required same behavior, but no indication that they were done to enhance same skill. There were three plans that related to sitting—one to assist the individual to sit on a chair while receiving enteral feeding, one to be a replacement behavior to increase appropriate request for a break, and one to stay on a vocational task five minutes. There was no indication these possibly related plans would result in programs that would complement each other. • For Individual #101, no use of communication skills was indicated as part of action plans. 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: • Lack of timeliness of assessments, as noted throughout this report, made it difficult to ensure information and recommendations from assessments could be integrated into ISP planning at the time of the annual planning meeting. • As reported in Provision I3, when risk to the individual warranted immediate action, the Facility took immediate action in two of 12 (17%) cases (Individuals #35 and #108) and integrated the plans into the ISPs in one (9%). • Integration of psychiatry and psychology services continued to improve. Each psychiatric assessment included a review of both the psychotropic and behavioral impact on the individuals. However, psychological and behavioral assessments and PBSPs did not provide evidence of combined assessment and case formulation. • As reported in Provision O2, PNMT recommendations were integrated as part of ISP Addendums (ISPAs) but not clearly integrated into Integrated Health Care Plans (IHCPs, which are part of the integrated plan for care). A positive example of integrating recommendations into ISPs involved inclusion of Head of Bed Evaluation recommendations into individuals' plans. • As reported in Provision O2, OT/PT interventions were not consistently integrated into ISPs or ISPAs. • As reported in Section R, there was little evidence that communication strategies were integrated in a functional manner with other supports and services, such as skill acquisition plans. Six of 14 ISPs reviewed (42%) contained skill acquisition	

#	Provision	Assessment of Status	Compliance
		programs to promote functional communication. Strategies were not integrated into existing SAPs and SAPS were not developed to address identified concerns with communication. A positive example occurred during the ISP annual planning meeting for Individual #118, during which the individual's communication dictionary was revised to permit greater use across services and supports.	
	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. Responsible Staff: Staff responsible was listed by job title. All Action Plan templates had a column that indicated "Persons Responsible for Implementation/Documentation." Each template also had columns for the "Person Responsible for Plan Development" and "Person Responsible for Reviewing for Progress and Effectiveness." Nearly all staff responsible for implementation were "PNA." For Individual #101, the person responsible for implementation was the QDDP (interestingly, the person responsible for plan development for all action plans was the direct care professional—the PNA). Timeframes for completion: Timeframes for implementation were consistently stated as the start date, and all start dates for each action plan was the same for each individual. For Individual #101, the start and completion dates were provided; they were the identical day. Methods for implementation: The ISP itself did not describe methods for implementation. Issues related to specifying the methods are described for SAPs in Section S, and for PBSPs in Section K. Presumably, methods for implementation of Integrated Health Care Plans (IHCPs) would be found in those plans; refer to Section M for discussion of IHCPs.	Noncompliance
	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	Interventions, Strategies, and Supports Effectively Address the Individuals Needs Zero of four ISPs reviewed provided prioritization of needs or rationale for selection of goals. In some cases, it was difficult to understand the choice of goals. For example: • For Individual #47, there were no rationales given for the selection of needs. For example, a goal was to allow a nurse to brush the individual's teeth; however, the Functional Skills Assessment stated the individual's level on toothbrushing was "Manipulation," indication someone else would do the task but not that the individual "active resists guidance to the point that manipulation is impossible."	Noncompliance

#	Provision	Assessment of Status	Compliance
		One rationale was provided—that there would be no self-administration of medications program because the individual received medication through tube. • One goal for Individual #79 was to name pictures in a magazine for leisure. It was difficult to identify how naming pictures would address a need to develop leisure skills useful in community settings. The individual did not have an action plan to address the use of a lift vest due to falls, nor for other interventions to reduce the number of falls. <u>Extent to which interventions, strategies, and supports are practical and functional</u>: As reported in Provision S3a, 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. Also due to the numerous limitations in the skill acquisition programs described in Provision S1, it was not possible to determine that SAPs were practical or functional. Observations reflected, and SAP data sheets supported, that formal programs were seldom implemented. In many instances, staff failed to demonstrate accurate and skillful implementation of SAPs. One of four ISPs reviewed (25%) included at least one measurable objective for community participation, for Individual #79. As reported in Provision S1, there was lack of clarity of methodology for skill acquisition programs; this made it difficult to determine how practical these programs were. 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.	
	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> The Monitoring Team found the Facility did not yet consistently identify in the ISP 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. • In four of four ISPs reviewed (100%), the Action Plan column titled "Data Sheet/Documentation Form" uniformly stated "Progress Note." The ISP did not identify data to be collected for IHCPs; these data were to be identified in the IHCP. As reported in Section M, the use of clinical data for the IHCPs was still evolving; as reported in Provision O7, there was little evidence of use of clinical data for monitoring physical and nutritional status identified in the IHCP.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The Facility provided a Risk Action Plan that accompanied the IRRF for Individual 29. Some items indicated a goal of 0 episodes for events such as choking, aspiration pneumonia, and fractures, so the measure would be evident. Others were less clear, such as "Improve oral hygiene" and "maintain fluid balance." For all except hypothermia, action steps were listed, and a position title was provided for person responsible for each action step. Monitoring was stated as "Quarterly" for each action step, and the same date was provided for implementation of all action steps. Outside the ISP itself, the Monitoring Team found the following issues and examples: • As reported in Provision K4, data collection for target behaviors was not sufficient to assess progress. There had been significant improvement in identifying data to be collected to assess progress on replacement behaviors. • In one of 24 Skill Acquisition Plans (SAPs) (4%), there was an adequate description of documentation practices. o For all 10 of the OT/PT SAPs (42% of the sample), data collection of individual skill development was not possible, as the SAPs did not involve the teaching of new skills. o For the remaining 13 of 24 SAPs (54%), instructions for data collection and documentation were vague, poorly developed and allowed for data to be collected too infrequently to be meaningful.	
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.	<u>Extent to which goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP:</u> This provision requires that disciplines work together and coordinate activity to achieve ISP goals, objectives, anticipated outcomes, services, supports, and treatments. The Monitoring Team found there were some examples of progress toward coordination: • For Individual #101, choking risk was addressed by both a ground diet and by inclusion of "food stealing" as a targeted behavior in a PBSP. However, zero of four ISPs reviewed (0%) showed evidence of coordination of services, supports, and treatments. One possible exception, as noted in Provision F2a3, was that Individual #79 had a program intended to reduce tactile defensiveness and did not have physical prompting in SAPs.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that	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. <u>Extent to which ISP is accessible to staff:</u>	Noncompliance

#	Provision	Assessment of Status	Compliance
	each ISP is accessible and comprehensible to the staff responsible for implementing it.	ISPs were accessible to staff as they were included in the active record and both the Residential and Vocational individual notebooks. As reported in Provision V1, these records were consistently available. <u>Extent to which ISP is comprehensible to staff:</u> 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, IHCPs), the goals and objectives of these plans, and the delineation of who is responsible for what with regard to the plans should be incorporated into the overall ISP. The assignment in the ISPs of responsibility 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. Because the ISP document did not, in itself, provide information on what to implement, or when and how to implement, the ISP itself was not adequate to guide implementation of supports and services. There was no single place that listed all supports and services that needed to be implemented. The standardized format did permit finding where specific issues and actions were addressed. Observations and review of program data indicated that, in terms of outcomes, the ISP did not appear to be comprehensible to the staff responsible for implementing it, as there were many instances in which staff could not describe supports contained in the ISP or did not implement them as called for in the ISP. Examples included: • As reported in Provision O4, staff were observed not implementing interventions and recommendations outlined in the PNMP and/or Dining Plan.	
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	To assess this requirement, the Monitoring Team interviewed the QDDP Manager, reviewed Active Records, and reviewed (in various sections of this report) whether clinicians performed reviews. It should be noted that some review of progress and efficacy is routinely done quarterly, such as quarterly nursing assessments and quarterly psychiatric reviews. This is to be supplemented by QDDP review. 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. The QDDP Manager stated documentation of monthly QDDP reviews had not been well-documented. Beginning in January 2013, QDDPs have begun to monitor one individual's SAPs per day.	Noncompliance

#	Provision	Assessment of Status	Compliance
	needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	Review by appropriate clinicians was not consistently done. • As reported in Provision K4, monthly reviews of PBSPs were not consistently carried out. Nine of 12 reviewed PBSPs (75%) were reviewed by a BCBA. Only four of 12 PBSPs (33%), however, were provided that review on a monthly basis. For the majority of the PBSPs without monthly review, the BCBA did not conduct a review until approximately six weeks later. For example, several February 2013 progress notes were not reviewed by a BCBA until the second week in April. For three of 12 PBSPs (25%), there was no documentation of a review for at least one progress note. • As reported in Provision M2, four of nine (44%) Quarterly Nursing Assessments were seriously overdue for nursing assessments. • For individuals with PNMPs or SAPs focused on indirect OT/PT services, for 0 of 12 individuals from Samples P.1 and P.2 (0%), there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. Monthly documentation from the OT and PT and/or QDDP did not include: o Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); o A description of the benefit of the program; o Identification of the consistency of implementation; and o Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress.	
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	<u>Competency-based Training on Development of ISPs</u> According to the Self-Assessment, two of four QDDPs (50%) had completed facilitation training—the Q Construction: Facilitating for Success training, which included a competency-based component. However, the QDDP Manager, in interview, reported that all four QDDPs (100%) were certified at the time of the visit. He reported that annual competency checks had been done for certified QDDPs and two new QDDPs had been certified. In response to a request for tools used to measure competency, the Facility provided a set of training materials for QDDP training and Supporting Visions training. These materials did include exercises and activities; however, they did not include tools to measure competency. Also, as described in the last compliance report for RGSC, "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 clinicians, including habilitation staff and Nurse Case Managers."	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.	Per interview with the QDDP Manager, DADS consultants and staff provided training on the current ISP process, including follow-up training the week prior to the compliance visit. Another example of training was reported in Provision M6. State Office staff provided Integrated Risk ISP/Risk (IRRF and IHCP) process training in October 2012. All RN Case Managers, along with RNs and LVNs attended the training. <u>Competency based Training on Implementation of Plans</u> The Facility did not have an overall process in place to ensure all staff, including pulled and relief staff, received competency based training on implementation of plans. However, a process had been put into place for Positive Behavior Support PLANS (PBSPs). The Monitoring Team reviewed the PBSP Competency Assessment Log. This spreadsheet listed the individuals who lived in each home and the staff who worked regularly in each home or in vocational services. A few staff were listed for more than one wing of a home, indicating the possibility that training was done for relief staff, but the Facility did not provide information to verify training for relief staff before they were responsible for implementing actions in the ISP. For individuals with PBSPs, the log listed dates of training and, for each staff, the percent correct (apparently, on a competency test). The Monitoring Team did not review the scoring form to determine how competency was determined. Thus, some training was provided on implementation of ISPs, and some tracking processes were in place. However, as noted in several sections of this report, staff were not able to describe, or did not accurately implement, services and supports listed in ISPs. The Facility will need to review its training and retraining practices to ensure staff are trained to competence and retain that information.	
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	<u>Extent to which ISPs are developed within 30 days of admission</u> Two individuals had been admitted since the last review but more than 30 days prior to this compliance visit. • Two of two (100%) received an OT/PT screening or assessment within 30 days of admission or readmission. • Zero of two (0%) received a psychological assessment within 30 days of admission or readmission. • For one of one individual reviewed for nursing assessments (100%), an Admission Comprehensive Nursing Assessment was completed within 30 days of admission. • Two of two individuals (100%) received a communication screening or	Noncompliance

#	Provision	Assessment of Status	Compliance
	written extension.	assessment within 30 days of admission or readmission. • For two of two (100%), a Reiss Screen had been conducted within 30 days of admission or readmission. • For Individual #115, an ISP had not yet been finalized and entered into the Active Record after 60 days. Thus, although assessments were done timely, ISPs were not consistently developed timely. <u>Extent to which ISPs are revised annually and as needed and put into effect within thirty days of preparation:</u> A table of ISP dates that included the prior ISP and the current ISP documented that 56 of 57 (98%) individuals who had resided at RGSC for over one year had the current ISP meeting within 365 days of the prior meeting. Thirty-six ISP meetings had been held between 10/1/12 and 4/18/13. Of those, at the time the undated document was produced, 32 (89%) were late or were pending submission, and four (11%) had been submitted timely. Although it is likely that all, or at least part, of the actions identified in the ISP would have been continuation of supports and services from the prior year or would have been initiated before finalizing and submitting the ISP, the Monitoring Team could not assess whether this was the case. To achieve substantial compliance, the Facility will need to make a significant effort to ensure ISPs are developed or revised timely.	
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.	As reported in Provision F1c, the Facility provided nine monitoring tool audits of ISP. There were numerous areas in which the Monitoring Team findings were inconsistent with the findings of these audits. Regarding comprehensive assessments, the audits uniformly found that comprehensive assessments were routinely conducted and used to identify strengths, preferences, and needs. As indicated by both Facility data and reviews of ISPs by the Monitoring Team, most assessments were not even completed in time for review by other IDT members prior to the ISP annual planning meeting. This puts into question the accuracy of this tool. The Facility did provide extensive data on timeliness of assessments and ISP annual planning meetings and attendance at ISP annual planning meetings. These data were not consistent with the monitoring tool audits and were likely more accurate. However, the Facility did not have a process to evaluate the comprehensiveness and quality of assessments, the relationship of ISP action plans to preferences and strengths of individuals, or other measures of quality other than what is found in the monitoring tools. Given the particular issues with timeliness of assessments, the Facility might	Noncompliance

#	Provision	Assessment of Status	Compliance
		choose to focus the development of quality assurance processes on issues needing immediate improvement.	

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

1. Revise the ISP Process SOP 600-01 to ensure consistency with statewide DADS policy. (Provision F1)
2. Provide training or consultation to assist IDTs in planning goals and action plans that address services, supports, and skill acquisition needed for success in transition to a more integrated setting. (Provision F1e)
3. Develop and implement a process to review and improve quality and comprehensiveness of assessments. (Provision F1c)
4. 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:** **Documents Reviewed:** 1. RGSC Self-Assessment 4/29/13 2. RGSC Action Plan 4/25/13 3. RGSC Section G Presentation Book 4. DADS draft policy #005: Minimum and Integrated Clinical Services 1/12/10 5. DADS Policy 009.1 Medical Care 9/6/12 6. RGSC Standard Operating Procedure (SOP) ICF-IID 400 17 Consultation Request Process 1/30/13 7. RGSC SOP ICF-IID 400-14 Medical Care July 2012 8. Monthly Attendance by Discipline report for 9/1/12-3/31/13 9. ISP assessments tracking log monthly report September 2012-March 2013 10. List by discipline of annual assessments filed within 10 days for annual meeting dates of 4/4/12-3/31/13 11. Assessment Filing-Number of Times filed later than 10 days for meetings between the dates of 4/4/12 and 3/31/13 12. ISPs for Individuals #29, #47, #79, and #101 M 13. Monthly Consultation Audit Report for 2012 and January-April 2013 14. Policy development emails, Professional Staff Organization Meeting minutes 3/25/13, and training sign-in sheets related to RGSC Policy ICF-IID 400 17 15. Morning Medical Report meeting minutes for 5/13/13, 5/14/13, 5/15/13, and 5/16/13 16. Settlement Agreement-Program Improvement Council reports from Business Meeting of 5/13/13 **People Interviewed:** 1. Lorraine Hinrichs (ICF-DD Director) and David Moron, M.D. (Clinical Director) **Meeting Attended/Observations:** 1. Morning Medical Report meeting 5/15/13 2. ISP Annual Planning Meetings for Individuals #118 and #134 3. Pre-ISP Planning Meeting for Individual #48
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section G. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section G, in conducting its self-assessment, the Facility: ▪ Used relevant data sources and/or key indicators/outcome measures. Data included attendance at ISP meetings by discipline. Data on consultations included number scheduled monthly, percent attended, and percent reviewed by Facility clinicians. Interestingly, data were provided for aspiration triggers, the first time a Facility used outcome clinical indicator data as a measure of possible integrated planning (a positive approach that could be expanded to other outcomes).

	▪ The Facility rated itself as being in compliance with neither provision of Section G. This was consistent with the Monitoring Team's findings. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as Completed, In Process, or Not Started. Some In Process actions, such as monitoring completion of consults, appeared to have been initiated and ongoing, as the Facility provided data on them. ▪ The Facility data identified areas of need/improvement. For example, the data on ISP meeting attendance indicated a need for improvement. ▪ The actions did not provide a set of steps likely to lead to compliance with all the requirements of this Section. For example, the only action planned regarding ISP meeting attendance was to review the data at the SA/PIC monthly meeting (the QA meeting for the Facility); no other actions were indicated. For other actions that only specified monitoring, it is understood that the data might not yet be available to indicate whether further actions are needed.
	Summary of Monitor's Assessment: The Facility had continued to progress toward providing clinical services in an integrated manner. Improvements had occurred through the Morning Medical Debriefing process, other committees and workgroups, and, to a degree, the ISP process. Continued implementation and improvement of the process of reviewing consultations had also occurred. Although the Facility had established several processes for integration of clinical services, there was still need for improvement in the actual integration of services. Nevertheless, the integrated discussions continued to provide opportunities for such integration to occur, and integrated discussion was evident in observed meetings if not in the documentation of services and supports. The Facility had established policy and practices that address the requirements for Facility clinicians to review recommendations from consultants. Facility clinicians documented review of recommendations by consultants and acceptance of consultant reports; progress notes were thorough and demonstrated follow up. Reporting at the morning medical meeting provided opportunity to inform clinicians from all disciplines and to ensure referrals are made to the IDT as needed. However, the Facility did not document that these referrals to the IDT were occurring. Documentation of a decision about whether to refer recommendations to the IDT would clarify whether this was an issue of lack of referral when needed, or of lack of documentation of the referral or the determination that a referral was not needed.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three	The Facility had continued to progress toward providing clinical services in an integrated manner. Improvements had occurred through the Morning Medical Debriefing process, other committees and workgroups, and, to a degree, the ISP process.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	<u>Integrated Care at Morning Medical Debriefing Meetings</u> One positive finding was the continued evolution of the Morning Medical Debriefing 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; since the last compliance visit, regular participation has been added by the Program Improvement Specialist, Director of Habilitation Services, BCBA, and QDDPs. The meeting had a standard agenda, that included review of items pending from previous days (including follow-up of unresolved or ongoing health issues, report of hospitalizations and ER visits, on call physician notifications and orders, notice of any restraints, medication treatment refusals, referrals from the nurses to the physician, consultation appointments, QDDP reports of IDT concerns, and weekly rotating topics including PNMT issues, weekly summaries of consultations and consultation results, skin integrity issues, and infection control issues. This provides an opportunity to communicate any issues requiring interdisciplinary involvement. 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 a meeting observed by the Monitoring Team, a discussion was held about an individual who had a fall and about an individual who had some coughing. There were no significant issues that would be expected to lead to review of systemic issues, but the discussions about individuals were useful. As reported in Provision O2, a method in which the PNMT was made aware of changes in status was through participation by the PNMT lead and PNMT RN in the morning medical meeting. Information from this meeting was then brought to weekly PNMT meeting for further discussion and shared with the IDT as indicated if not already done so. <u>Other Integrated Committees and Workgroups</u> • The Physical and Nutritional Management Team (PNMT) was an interdisciplinary workgroup that met weekly. Assessments included information at a minimum from habilitation and nursing disciplines. However, attendance by core members needed improvement. Reviews of Individuals #108 and #19 by PNMT and development of action plans reflected integrated planning to address changes in status. • The Nursing Department reported a Skin Integrity Committee Meeting was conducted for the first quarter in March 2013. However, the minutes of the Skin Integrity Committee Meeting minutes were not available for review. Neither was documentation provided that described the purpose/function of the committee or a list of core membership. <u>Examples of Integrated Planning</u>	

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		• Per interview with the QDDP Manager, the Facility was able to return to having Nurse Case Managers share caseloads with QDDPs, except for a few individuals. The Case Managers and QDDPs have offices in the same wing to permit ready access to each other and enhance communication. The offices of home managers are now also in the same wing. • As reported in Sections J and K, integration of psychiatry and psychology services continued to improve. Each psychiatric assessment included a review of both the psychotropic and behavioral impact on the individuals. However, psychological and behavioral assessments and PBSPs did not provide evidence of combined assessment and case formulation. The psychiatrist and psychologist met weekly to review and assess the integration of non-psychotropic therapies with psychotropic therapy. • In interview, Dr. Moron provided an example in which he and the psychologist jointly reviewed an individual and determined that the diagnosis of autism should be made, which led to the possibility of changing the individual's medication to one studied more with autism. He also gave an example gave an example of an individual for whom the pharmacy pointed out the individual, on Remeron, was showing increased triglycerides; pharmacist, physician, Dr. Moron discussed; they developed a plan to keep Remeron but involve the dietitian and review diet and exercise to address the triglyceride level. <u>Integration of Services into ISPs and Programs</u> The Monthly Attendance by Discipline report for 9/1/12-3/31/13 documented a range of attendance by discipline ranging from 0% (for Active Treatment staff—zero of one required meeting) and 12% for physicians to 100% for several disciplines. 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. Based on attendance data, they physician did not attend ISP annual planning meetings. Given the physician staff at the Facility, it is understandable that the physician cannot regularly attend, but processes should be in place to permit attendance when medical issues are substantive for an individual so that integrated planning can take place; this might require scheduling of the ISP annual planning meeting or of a supplemental meeting at a time that would permit physician participation. This information was consistent with that provided in the self-assessment. The Monitoring Team reviewed recent ISPs for Individuals #29, #47, #79, and #101 to determine attendance at each of the annual planning meetings. For clinical disciplines, the number present ranged from four to eight. Disciplines present at 100% of meetings were nursing and vocational services; disciplines present at 25% or less of the meetings	

#	Provision	Assessment of Status	Compliance
		included primary care provider (PCP), dental services, occupational therapist/physical therapist (OT/PT), and pharmacy services. This was relatively consistent with the percentages reported for most disciplines on the monthly attendance by discipline report, except that report showed 57% for PT and 69% for OT, and 100% for psychology assistant. As noted in other Sections of this report, physicians did not regularly attend the ISP annual planning meetings, an OT or PT participated consistently, and a speech pathologist attended but not consistently. While 100% of PNMT recommendations were clearly integrated as part of the ISPA and were included as part of the risk action plans primarily in the form of following the PNMP, recommendations were not clearly linked or integrated into the IHCPs. <u>Examples of the Need for Improved Integration</u> • As reported in Provision J10, the Monitoring Team could not identify evidence to indicated that before starting a non-emergency psychotropic medication that an IDT review was held and included a review by all relevant staff, including the nurse, and primary care physician, and discussed the risks and benefits of starting the new drug, and if reasonable alternative strategies would be beneficial; however, the Monitoring Team did determine that the psychiatrist and psychologist discussed relevant details regarding initiation of starting a new psychotropic medication. • Involvement of speech pathology in the PBSP process needs to improve. Communication programs frequently serve to develop or increase communication as a replacement behavior for target behaviors. Based on review of the Positive Behavior Support Committee meeting attendance sheets from 9/24/13 to 2/25/13, participation by a SLP was noted in zero of the 18 meetings (0%). It would also be helpful 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. This did not appear to be consistently occurring as evidenced by the lack of integration and collaboration of the plans of care. • As reported in Provision K8, use of sensory integration procedures, related to addressing behavioral issues, by SLPs and OTs/PTs did not incorporate behavioral assessment procedures or individualized assessments. <u>Conclusion</u> Although the Facility had established several processes for integration of clinical services, there was still need for improvement in the actual integration of services.	

#	Provision	Assessment of Status	Compliance
		Nevertheless, the integrated discussions continued to provide opportunities for such integration to occur, and integrated discussion was evident in observed meetings if not in the documentation of services and supports.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	<u>Policy</u> RGSC SOP 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. The Clinical Director, in interview, stated that all consultations require an order from a physician, so all would be covered by the requirements of this policy. RGSC SOP ICF-IID 400 17 Consultation Request Process had been implemented in January 2013 to guide the consultation process. Consistent with the report of the Clinical Director, this policy states that "consultation requests should be ordered by the Primary Care Physician, reviewed by the appropriate clinicians and disciplines, and recommendations should be implemented as determined by the IDT." This policy includes not only the consultation request and information required in the packet but also: • Scheduling of the consult and notice to the morning medical meeting (also called the Morning Medical Report meeting); • The process for providing the consultant with the consult packet; transportation of the individual to the consultant; returning the consultation form to the Facility; • Provision of the information to the appropriate primary care provider (PCP); • Actions required of the PCP to review the report, document recommendations that require immediate attention, complete the remainder of the documentation on the consult form within five business days of the completed consult, and present significant findings and recommendations at the morning medical meeting; • Determination at the morning medical meeting if an ISPA meeting is necessary; • Filing of the completed and signed consult report; • IDT notification, including notification of the legally authorized representative (LAR) or primary correspondent; and • Tracking and reporting of consults, review of the data weekly at the morning medical meeting, and trending and analysis by the Clinical Director with report to the Settlement Agreement-Program Improvement Committee monthly. This comprehensive policy covers the major issues of consultation and, if implemented accurately, should lead to compliance with this provision.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Review of Consultations by Facility Clinicians The Monitoring Team reviewed a sample of 15 consultation reports for 11 individuals (Individuals #2, #5, #33, #40, #59, #62, #77, #114, #115, #132, and #133). Twelve reports were for medical consultations, and three were for barium swallowing studies (MBSS). For twelve of 12 medical consultations (100%), documentation of PCP review was provided on the consultation report and in an integrated progress note (IPN). Integrated progress notes thoroughly documented follow up to the consults. For three of three MBSS consultations (100%), documentation of review was provided in an integrated progress note. For 15 of 15 consultations (100%), there was documentation that the facility clinician accepted the recommendation of the consultant. For 0 of 12 medical consultations (0%), there was documentation on the consultation form or in the IPN of referral to the IDT. However, the Facility had a process in place (as required by Policy 400 17) to filter consultations through the morning medical meeting. For four of four minutes reviewed (100%), consultations to be done and consultations missed were reported. Recommendations for follow up appointments were also reported. The form for minutes of these meetings included an agenda item for "IDT Referrals/Concerns." Minutes of the morning medical meeting of 5/16/13 reported discussion of an IDT concern involving physical and nutritional management for Individual #140. Actions included referrals to the speech pathologist and PCP for review of specific issues and for consideration of scheduling a consultant appointment. For the remainder of the meetings, minutes did not reflect any referrals to the IDT or concerns from the IDT. Zero of four minutes reviewed (0%) reported referral to the IDT. Therefore, this process provided information about consultations to be done, follow ups recommended, and missed appointments with information about rescheduling but did not provide evidence of referrals to the IDT based on recommendations from consultations or of discussion of the recommendations during the morning medical meeting that might lead to a determination of whether referral to the IDT was necessary. For 0 of three MBSS consultations (0%), there was documentation of an ISP meeting to discuss modification of food texture based on recommendations in the MBSS reports. Therefore, it was not clear that recommendations were referred to the IDT.	

#	Provision	Assessment of Status	Compliance
		The agenda lists a weekly presentation of data on consultations ("Consult Weekly Report/#s ordered/attended/etc.") on Tuesday. Minutes for the meeting of Tuesday, 5/15/13 did not document the presentation. A weekly discussion of the consultations would be useful for tracking and determining whether any improvement actions should be taken; to be most useful, it should include information on referrals to IDTs. In addition to review of data weekly at the morning medical meeting, data on consultations were to be reviewed at the monthly SA-PIC business meeting. Documentation of the SA-PIC business meeting of 5/14/13 included longitudinal data for all of 2012 and for 2013 through March on number of scheduled and rescheduled consultations, reasons for appointments not kept, and numbers of consult reports received and reviewed by facility clinicians. Also included was the CATW2 (see Section E for description of this process) from 3/8/12 that included some suggestions for improvement on keeping appointments. <u>Conclusion</u> The Facility had established policy and practices that address the requirements of this provision. Facility clinicians documented review of recommendations by consultants and acceptance of consultant reports; progress notes were thorough and demonstrated follow up. Reporting at the morning medical meeting provided opportunity to inform clinicians from all disciplines and to ensure referrals are made to the IDT as needed. However, the Facility did not document that these referrals to the IDT were occurring. Documentation of a decision about whether to refer recommendations to the IDT would clarify whether this was an issue of lack of referral when needed, or of lack of documentation of the referral or the determination that a referral was not needed.	

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

1. Add to the draft DADS policy by specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring. (Provision G1)
2. Provide training, review and mentoring, or another process to assist clinicians to develop integrated case formulations and treatment recommendations and to develop documentation that clearly demonstrates this integration in PSPs and the active record. (Provision G1)
3. Ensure assessments are developed timely and posted for review by IDT members in preparation for annual ISP planning meetings. (Provision G1)
4. Ensure that reviews of consultation document notice referral of recommendations to the IDT as appropriate. (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:** **Documents Reviewed:** 1. RGSC Self-Assessment 4/29/13 2. RGSC Action Plan 4/25/13 3. RGSC Section H Presentation Book 4. DADS Policy 004.1 Individual Support Plan Process and attachments (11/20/12) 5. DADS Policy 009.1 Medical Care 9/6/12 6. RGSC SOP HIM400-15-ICF ICF-DD Transcription of Clinical Assessments 3/26/13 7. RGSC Standard Operating Procedure (SOP) ICF-IID 600-01 Individual Support Plan Process (August 2012) 8. List titled Additional Indicators 9. RGSC Quality Assurance Plan-Revised 4/18/13 10. ISP assessments tracking log monthly report September 2012-March 2013 **People Interviewed:** 11. Lorraine Hinrichs (ICF-DD Director) and David Moron, M.D. (Clinical Director) **Meeting Attended/Observations:** 12. Morning Medical Report meeting 5/15/13 13. ISP Annual Planning Meetings for Individuals #118 and #134 14. Pre-ISP Planning Meeting for Individual #48
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section H. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section H, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tool the Facility used the Section I "At Risk" Tool to conduct its self-assessment. o It was unclear whether this tool included adequate indicators to allow the Facility to determine compliance with the requirements of Section H. The self-assessment reported the same overall percentage of compliance data for each provision assessed, rather than identifying compliance with items on the tool relevant to each provision. Overall compliance data reported did not indicate level of compliance with each provision. For example, overall percentage of compliance on the monitoring tool did not provide evidence regarding whether clinical indicators of the efficacy of treatments and interventions were determined in a clinically justified manner (Provision H4). The Facility

	is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ▪ Used other relevant data sources and/or key indicators/outcome measures. Examples of relevant data included: o Percent of assessments posted on the share drive timely. This was an important and relevant measure of whether assessments were performed on a regular basis. o Results of Medical Provider Audits. Although potentially useful, this raises the same concern as the use of the Section I monitoring tool—that overall percentages do not provide information that helps evaluate compliance with specific requirements of provisions; the Facility should consider identifying audit items relevant for each provision. o Percent of Active Problem Lists available, current, and with updated and accurate diagnoses. This information is useful in assessing compliance with multiple provisions but needs to be supplemented with some type of review to evaluate whether the diagnoses clinically fit assessments; this may have been done as part of determining whether diagnoses were accurate, but that methodology was not reported as part of the self-assessment. o Percent of records that have a conflicting Axis II diagnosis (apparently, between CWS and hard-copy of the record). This is valuable information that the Facility should use as part of its quality assurance efforts. The Facility reported a 13% conflict rate was compliant; this may be acceptable for systemic review, but even that level could indicate misinformation that could lead to poor interdisciplinary decisions on treatments based on inaccurate diagnoses. The Monitoring Team assumes corrections are made when conflicts are discovered. o Information about the Medical Morning Meeting agenda. This type of information is useful as it identifies status of process changes related to actions planned to achieve compliance. ▪ The Facility consistently did not present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Did not present findings consistently based on specific, measurable indicators. As noted above, the use of overall compliance scores did not provide information on compliance with specific provision requirements. o Did not consistent measure the quality as well as presence of items. Only presence of assessments and whether assessments address preferences, strengths, and needs was measured, for example, and not comprehensiveness or quality of the assessments or of the identification of preferences, strengths, and needs. ▪ The Facility rated itself as being in compliance with Provision H2 and not in compliance with the remainder of the provisions. This was consistent with the Monitoring Team's findings. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as Completed (for implementing the DADS ISP process at annual staffing) and In Process (for all other actions). Many of the In Process actions appeared to be ongoing activities for which a process had already been developed, such as tracking assessments and

	reporting the findings. The Facility needs to identify what new processes need to be put into place in order to move from current practices to compliant practices. An example of such an action listed by the Facility as In Process was to develop a tracking tool to monitor data from tracking assessments. ▪ It was unclear whether the actions were based on analysis of status or data to prioritize areas of need/improvement. • The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. Many actions involved monitoring, meeting with staff, or reporting information, but there were no further actions to identify gaps between current practice (or what may be identified during monitoring and meeting) and the requirements of the provisions being addressed. For example, regarding Provision H7 requirements to establish and implement policies, there was no analysis of what issues are not yet covered by policy, and what actions will be needed to establish or revise policies and to implement those new or revised policies. This concern about the action plan was described also in the last compliance report, and the specific example in that report remains valid.
	Summary of Monitor's Assessment: 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. Unfortunately, this finding is identical to that found in the report from the last compliance visit. The Facility should take more assertive action to meet the requirements of this Section. Provision of assessments on both a regular basis and in response to change in health or behavioral status was not consistent across all disciplines. Diagnoses were consistent with the current versions of the DSM and ICD classification systems, and were generally consistent with the supporting assessments. However, it will be important for the Facility to review this report and the last one to identify areas in which more precise diagnosis (such as type of seizure) should be provided. 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. The Facility had done some limited expansion of development and use of systemic clinical indicators of efficacy of treatments and interventions in health care and other clinical areas. This remained in early stages and requires further development, both of a broader range of clinical indicators and of use of those in assessing status and planning improvements. The Facility had demonstrated significant improvement in timely provision of treatments and interventions. Continued improvement was noted in assessing acute medical conditions proactively and

	responding promptly. The Facility had made some progress on establishing processes to monitor the health status of individuals. One example was the continuing evolution of the Morning Medical Debriefing. 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.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	<u>Extent to which assessments are conducted routinely</u> DADS Policy 004.1 continued the requirement that IDT members complete required assessments and place them in the shared drive for IDT review no later than 10 working days before the annual ISP meeting. RGSC SOP ICF-IID 600-01 had the same requirement. As reported in Provision F1c, assessments were not consistently completed timely. The Facility provided a tracking log for each month from September 2012 through March 2013. Review of this log showed the total assessment completion rate and the timely assessment completion rate by department. Timely completion rates were 32% or below for each month. As reported in other sections of this report, specific assessments were not timely. • Psychological evaluations had been completed at least annually for 46 of 60 individuals (77%). • As reported in Provision M2, of the nursing quarterly assessments reviewed, five of nine (56%) were completed recently. Four of the nine (44%) were seriously overdue for nursing assessments. The Monitoring Team reviewed nine nursing assessments that were provided for the most recently completed and found four were significantly overdue for two or more quarters. This was consistent with data reported in the Facility's self-assessment. • Two of 10 individuals' OT/PT assessments in sample P.1 (20%) were dated as having been completed at least 10 days prior to the annual ISP. Assessments for newly admitted individuals were not consistently completed within 30 days. • Two of two admitted individuals since the last review (100%) received an OT/PT screening or assessment within 30 days of admission or readmission. • As reported in Provision K7, based upon tracking data provided by the Facility, two individuals had been admitted to RGSC since the previous site visit. Records reflected that neither of these individuals (0%) had been provided a	Noncompliance

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		Psychological Assessment within 30 days of admission. Tracking data reflected that neither individual (0%) had been provided a Psychological Assessment since their admission. • Through computer randomization, the Monitoring Team selected Individual #115 to review timeliness of assessments; review took place 5/15/13. This individual was admitted in March 2013. Of 13 assessments that should have been completed within 30 days, seven (54%) had been completed timely. One additional assessment had been completed within the prior week, well over the 30-day timeline. <u>Extent to which assessments are conducted in response to significant changes:</u> There was improvement in conducting assessments in response to significant changes, but there remained instances in which assessments were not updated when the need arose. For example: • As reported in Provision L1, there was improvement in post-hospital follow up by medical providers. However, there were cases of dehydration diagnosed by the hospital but not mentioned in the post-discharge follow note. • Also as reported in Provision L1, a positive finding was that swallow studies were completed following each case of pneumonia in four out of four cases reviewed (100%). • As reported in Provision M1, there had not been appreciable improvement in nursing assessments of individuals with acute changes in status. • As reported in Provision O2, individuals were appropriately referred to the Physical and Nutritional Management Team (PNMT) when they experienced a change in status. However, the Monitoring Team was unable to determine if PNMT assessments were initiated timely, as the evaluation did not provide a clear referral date, nor was the Monitoring Team able to determine if PNMT assessments were completed timely, again due to lack of date of referral and initiation of the assessment. • As reported in Provision P2, OT/PT assessments were not consistently completed in response to a change in status. However, two of two individuals (100%) identified with therapy needs received a comprehensive OT/PT assessment within 30 days of identification. <u>Use of Information From Assessments</u> Furthermore, information from the assessments was not always used in planning services and supports. • Although information from assessments was referenced during these meetings, the following examples identify situations in which the IDT could have used such information to make more informed decisions.	

#	Provision	Assessment of Status	Compliance
		o For Individual #134, there was discussion of money management; during the meeting, the IDT tested his ability to count coins, rather than first see what the Functional Skills Assessment (FSA) reported. There was no discussion of referring to the FSA to determine what skills the individual demonstrated and what would be an appropriate next step in teaching new skills. o For Individual #118, the only discussion of how skill acquisition programs (SAPs) could be selected that will assist in community living related to self-administration of medication (SAM). No assessment information was discussed when identifying a skill to be trained. A communication skill—push a button when he gets to the medication pass area—was selected without reference to current communication skills or to assessment of the environment to which he might move to determine whether this skill would be useful. • As reported in Provision S1, there were indications that some disciplines were achieving at least limited success at basing SAPs upon assessments. Although not approaching the level required for substantial compliance, the SLP SAPs at times were based upon adequate assessment.	
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. For individuals #55, #27, #59, #4, #33, #63, #149, #140, #2, and #79, all psychiatric diagnoses were documented appropriately, per DSM-IVR classification for psychiatric diagnosis, and all diagnoses were based on DSM-IVR criterion. For medical diagnoses, there were some issues in determining whether diagnoses fit assessments, even though the diagnoses were consistent with ICD-9. • Most individuals with a diagnosis of cerebral palsy had the diagnosis listed as history of cerebral palsy, although these should have been listed as active diagnoses. • For individuals #72, #118, #51, #15, #82, #12, #29, #60, and #145, one out of nine (11%) indicated an accurate diagnosis, specific for the type of seizure disorder. This had been noted in the report from the last compliance visit and should be corrected. However, other information provides examples in which assessments supported medical diagnoses. For example: • As reported in Provision L1, there was improvement in the Facility's assessing of pneumonia by the physician, since the last review. Moreover, four out of four	Substantial Compliance

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		cases (100%) were noted to have had imaging studies to help determine resolution of pneumonia. • Regarding osteoporosis, nine out of ten individuals reviewed (90%) had evidence that a diagnostic was obtained to evaluate bone density. At the last compliance visit, the Monitoring Team rated the Facility as being in Substantial Compliance. The Facility has maintained its practices, and remains in substantial compliance, but it will be important for the Facility to review this report and the last one to identify areas in which more precise diagnosis (such as type of seizure) should be provided.	
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. However, as indicated in Provision L1, there had been improvement in timeliness of medical care. Nevertheless, issues remained. Examples of both timely and clinically appropriate clinical care, and of lack of such care, included: • As reported in Provision L1: o Review of a sample of individuals who had acute medical conditions found that five of five cases (100%) demonstrated a comprehensive initial evaluation that included a clinical impression and plan. o Initial triage by the physician of the one reported diagnosis of cancer was timely, and clinically appropriate. o There was a medical plan documented on the annual medical assessment for osteoporosis in nine out of ten cases (90%). • As reported in Provision P1, zero of four individuals (Sample P.3) (0%) who experienced falls were appropriately reviewed by the IDT. Individuals who experienced multiple falls did not have evidence of team discussion regarding the situation in which the falls occurred and factors potentially impacting the occurrence. • As reported in Provision P2, four of four individuals' intervention plans (100%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. • As reported in Provision K4, 67% of PBSPs indicated modifications reflected data-based decisions. However, there were examples in which modifications were not made despite data indicating a need. o For Individual #44, the March 2013 progress note reflected that aggressive behavior had been above baseline for four of seven of the previous months (57%). In December 2012, the recommendation was	Noncompliance

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		made in the progress note for the IDT to review the increase in aggression. No documentation provided by the Facility reflected that such a review was provided or that the PBSP was determined to be adequate. o For Individual #101, aggression remained above baseline for eight of the previous nine months. During the second through fourth months after the PBSP was implemented, episodes of aggression occurred at 400% of the baseline level. Episodes of aggression later decreased, but remained above baseline for all but one month. Thus, the Facility had demonstrated significant improvement in timely provision of treatments and interventions. Continuing improvement, particularly greater attention to behavioral data and falls, should allow the Facility to achieve substantial compliance.	
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 provided a list titled Additional Indicators. This list identified person responsible, data/indicator, review frequency, and team reviewing. Some clinical indicators useful for assessing status of healthcare and other clinical care were included: • BMI (body mass index) • Restraint • Stat Meds • ADR (adverse drug reactions) Although this list provides a beginning, it does not provide a comprehensive set of clinical indicators of efficacy of treatments and interventions. In interview, the Clinical Director reported implementing tracking of episodes of possible aspirations and constipation. As noted in Provision G1, the Facility identified in its self assessment that tracking of aspiration triggers could be a sign of improved integrated clinical services. However, tracking of bowel elimination data may not have provided reliable information. If the information was reliable, it was not used to make appropriate treatment decisions. For some individuals, extended periods went by with no documented bowel eliminations. Therefore, if this is to be used as a clinical indicator, the Facility will need to ensure the data are accurate and that the data are used in making clinical decisions about treatment. Furthermore, assessments did not consistently include measurable outcomes. • As reported in Provision O2, review of records of individuals referred to the PNMT found that assessments contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. This was a positive finding.	Noncompliance

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		▪ However, as reported in the same provision, for individuals discharged from PNMT services, zero of one individual's (0%) discharge summary/action plan provided objective clinical data to justify the discharge. • As reported in Provision P2, for zero of four individuals' records (0%) reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. Measurable outcomes were not included as part of the ISP or ISPA but were clearly included as part of the OT/PT plan of service. • As reported in both Provisions K8 and P2, for individuals receiving a sensory diet or sensory integration services, none had indication of clinical indicators to be used to assess progress or make treatment decisions. • As reported in Provision P3, progress notes for individuals receiving direct/restorative OT/PT Services did not contain information regarding whether the individual showed progress with the stated goal including clinical data to substantiate progress and/or lack of progress with the therapy goal(s). As reported in Provision L3, the clinical director informed the Monitoring Team that the Facility did not have a quality assurance process to assess clinical outcomes. Although the Facility had begun to track indicators for episodes of possible aspiration and constipation (and presented these to the Medical Executive since 2/20/13), and had added and scheduled for review tracking of BMI, lipids, seizures, and A1c (related to diabetes), there was not yet a process to bring this information together into a medical QA process. The Facility did provide a document titled Additional Indicators. Attached to this document was the RGSC Quality Assurance Plan revised 4/18/13. In addition to episodes of aspiration triggers, BMI, adverse drug reactions, and Stat Meds, the indicators included injury, falls, restraint, and "Review of benzodiazepine(.)" These are all appropriate indicators that might be used to assess quality of clinical services, but the list is not comprehensive. There was no indication of exactly what is to be measured when a given indicator could have a variety of measures; for example, it did not indicate whether restraints would include only crisis intervention restraint or also would include medical restraints, or whether the measure would be number of individuals or number of episodes. The Quality Assurance Plan spreadsheet did not provide greater clarity. The self-assessment for Provision H5 did state that the Facility reviewed trended data on a number of additional possible clinical indicators of the status of health care at the Facility: hospitalizations, pneumonias, aspiration pneumonias, infectious diseases, seizures, constipations, falls, restraints and aggression. Again, though, this does not provide a clear list of precisely what was measured, and the list is not comprehensive. Progress in identifying, tracking, and using clinical indicators for assessment of progress	

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		for individuals and for health care in general had continued to be made but was limited.	
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 made some progress on establishing processes to monitor the health status of individuals. One example was the continuing evolution of the Morning Medical Debriefing, as discussed in Provision G1. Another example, reported in Provision O2, is that plans resulting from PNMT recommendations included specific clinical indicators of health status to be monitored. As documented in several provisions, the processes in place at the Facility did not yet ensure that changes in status led to action. • Problems with timeliness of assessments affected the accuracy of knowledge of health care status of individuals. • Although the at risk process using the Integrated Risk Rating Form (IRRF) had improved, the at-risk process had not yet developed to the phase of being able to identify and use the clinical indicators necessary to reliably determine risk level, show whether or not individuals' action plans were successful, or effectively monitor the health status of individuals. The completion of the Integrated Risk Rating Form (IRRF) at the time of the ISP and subsequent changes to IRRF based on ISPAs would provide opportunities to capture information that demonstrated the health status of individuals was being monitored. There were problems in monitoring, documenting, and tracking health status, as the following examples show: • As reported in Provision L1, although physician management of acute medical conditions had improved, progress notes by the physician did not consistently document follow up to full resolution. • As reported in Provision O7, records did not contain evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans was monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans, IPNs and data from the PNM related monitoring forms. QDDP monthly reviews provided no information regarding status of the individual or if the individual had any issues related to PNM or if the plan had been revised over the past month. • As reported in Provision P3, progress notes for individuals receiving direct/restorative OT/PT Services did not contain information regarding whether the individual showed progress with the stated goal including clinical data to substantiate progress and/or lack of progress with the therapy goal(s).	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with	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. RGSC had taken	Noncompliance

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	full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	steps to develop clinical pathways and practices, and had identified a few clinical indicators to track routinely and to use in monitoring individual health status. However, progress in expanding the identification and use of clinical indicators as noted in Provision H4, and in developing clinical pathways, had been minimal since the last compliance visit. Clinical indicators should provide one source of information used in assessment of risk. As reported in Provision I1, the substantive content of the clinical data used to determine risk ratings for the six risk groups in the Integrated Risk Rating Form (IRRF) showed improvement. Continuing improvement is needed. During the ISP annual planning meetings observed during the visit, considerable clinical data was used in establishing risk ratings for Individual #118, and some clinical data was used for Individual #134. The requirements of this provision related also to other clinical disciplines in addition to 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. Modification of treatments and interventions in response to clinical indicators was not consistent. • One positive example was reported in Provision O2 regarding PNMT assessments. Two of two (100%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. This information was contained within the Habilitation Assessment as well as part of the PNMT Assessment and PNMT minutes. • Zero of one individual's (0%) PNMT discharge summary/action plan provided objective clinical data to justify the discharge. • As reported in Provision K4, although improvement was noted in relation to data based modifications to PBSPs, there continued to be circumstances in which documentation did not reflect a review of available data. Examples included continuing levels of aggressive behavior above baseline for Individuals #44 and #101 with no modification of interventions. • As reported in Provision M1, although facility-wide systems had been put in place to improve the integration and management of acute change in individuals' health status, there was no appreciable improvement found in nursing's assessments and documentation of individuals with acute changes in status. It was not clear what clinical indicators were to be monitored when the nurses' notes stated, "will continue to monitor."	
H7	Commencing within six months of the Effective Date hereof and with	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	extensive information about clinical policies and procedures. This policy had not been revised since the last compliance visit. A draft DADS state policy addressed provisions G and H together. Although this policy had been initiated in November 2010, it had not yet been completed and implemented.	

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

1. Track assessments, diagnoses, and diagnostic updates to ensure assessments and evaluations are done both monthly, quarterly, or annually as required and in response to changes in an individual's status. Where tracking indicates assessments and evaluations are not completed timely, the Facility must develop systemic improvement actions to improve timeliness.(Provision H1)
2. Identify and implement processes to review clinical assessments for comprehensiveness and quality. (Provision H1)
3. Continue to develop a comprehensive list of clinical indicators across all clinical disciplines. (Provisions H4, H5, and H6)
4. When clinical indicator data suggest unacceptable results, there should be evidence that the current treatment plan was altered by performing additional assessments and diagnostics or modifying therapeutic regimens. (H6).

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Self-Assessment 4/29/13 2. RGSC Action Plan 4/25/13 3. RGSC Section I Presentation Book 4. DADS At Risk Policy 6.2 updated 12/7/12 5. RGSC SOP MR 400-02 At Risk Individuals revised 8/12 6. RGSC SOP NR-400-45 At Risk Patient/Individuals 5/13 7. Records for Individuals #5, #11, #35, #40, #47, #55, #66, #79, #98, #101, #108, and #114 8. Records for Sample #1 in Section O P**eople Interviewed:** 1. Lorraine Hinrichs, ICF-MR Program Director and Section I Lead 2. Jane Augustine, PT Director of Habilitation Services **Meeting Attended/Observations:** 1. Incident Management Review Team (IMRT) 5/13/13 2. Settlement Agreement Performance Improvement Council (SA-PIC) 5/14/13 3. PNMT meeting 5/14/13 4. Morning Medical meeting 5/16/13 5. Individual Support Plan (ISP) annual planning meeting for Individuals #118 and #134
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section I. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section I, in conducting its self-assessment, the Facility: ▪ Used the standard DADS monitoring/auditing tools. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as observations, interviews, record reviews. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed. The sample sizes were adequate to consider them representative samples. o The monitoring/audit tools did have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: ICF Director, QE Nurse, and Physical Nutritional Management Team (PNMT) members. o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically/programmatically competent in the relevant area(s).

	○ Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ Used other relevant data sources and/or key indicators/outcome measures including a review of a sample of risk rating forms, review of Integrated Health Care Plans (IHCPs), and review of the risk database. The self-assessment reportedly included a review of Facility policies addressing risk however this did not appear to be the case (refer to Provision I.1). ▪ The Facility presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: ○ Presented findings based on specific, measurable indicators ○ Measured the quality as well as presence of items. ○ Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with none of the following provisions of Section I. This was consistent with the Monitoring Team's findings. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as continued monitoring of records, tracking assessments, diagnoses, and diagnostic updates. All were reported as "in process". ▪ The Facility data did not identify specific areas of needed improvement in administrative practices, noting only generic statements such as "to ensure the IDT effectively responds to changes in health status of Individuals." ▪ The actions did not provide a set of specific steps likely to lead to compliance with the requirements of this Section as noted above.
	Summary of Monitor's Assessment: In its last report the Monitoring Team noted limited improvement from that previously observed. This continued to be the case. From this review the Monitoring Team noted: • 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. • The compliance rates reported by the Facility through its QA monitoring had not improved, and in fact in some areas declined, since the last review. The Monitoring Team observed the two ISP planning meetings that were held during the week of the review with mixed results regarding risk review, use of clinical data, 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. This observation was also made in the last report by the Monitoring Team. The Facility had not updated its At-Risk policy (ICF-IID 400 02) to include revisions associated with the most recent revisions to State policy. The Facility had not conducted a comparative review between its general At-Risk policy and the at-risk

	policy in the Nursing Manual to ensure consistency between the two policies.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The Facility's policies directed at this section of the SA were in need of review and updating. DADS At Risk Policy 6.2 was updated in December, 2012 however the RGSC SOP MR 400-02 At Risk Individuals was last revised in August, 2012. There are very likely elements of the most current version of State policy which are not reflected in the Facility policy. For example, the Facility policy does not specifically reference use of the seven forms required by the State policy. The Facility reported it had not as yet reviewed its policy in light of State policy changes. Additionally, the Facility had a nursing policy (RGSC SOP NR-400-45 At Risk Patient/Individuals) which was last updated in May, 2013 (apparently just preceding the May review by the Monitoring Team). The Section Lead for Section I reported the Facility had not reviewed this policy in the context of either the State or Facility At-Risk policy to ensure compatibility. The Facility needs to conduct a thorough review of all three policies to ensure they are consistent with one another and are providing adequate policy direction to the at-risk process. As reported in this Section, and in Sections O and M of this report, there are multiple issues with the at-risk process at the Facility some of which could be attributable to inconsistent policy direction. In order to maintain a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk this must be corrected. The Facility's administrative process to ensure regular risk screenings and assessments to consistently identify individuals whose health or well-being was at risk was not working well. The Facility self-assessment reported that 13% of the Individuals living at the Center had not received a timely Integrated Risk Rating Form (IRRF), 68% of required assessments were not completed timely, and only 33% of the IRRFs reviewed met the Facility criteria for completeness and correctness. The Facility QA process calls for the QA department to review one record quarterly using the State monitoring tool. This review reported declining compliance scores from 79% to 73% to 54% for the most recent quarter reviewed. The Monitoring Team reviewed the risk assessment planning associated with 10 individuals. Sample O.1 consisted of a non-random sample of individuals who were chosen from a list provided by the facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis], require mealtime assistance and/or are prescribed a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in	Noncompliance

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		relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. Six of ten individuals in Samples O.1 (60%) were provided with an accurate risk score related to all of the PNM risk areas (i.e., respiratory compromise, GI, skin breakdown, falls, fractures, aspiration, and choking, or others relevant to specific individuals). Examples in which risk was not accurately identified included: • Individual #47 was listed as high risk of aspiration but low risk of respiratory compromise. If an individual is at risk of aspiration then the risk of compromise to the respiratory system is increased as aspiration directly impacts respiration. • Individual #139 was noted per Swallow Study (MBSS) to have delayed laryngeal closure but was listed as being at "Low" risk for aspiration. Another concern was the inconsistency of identified risk levels between different documents. Please see Provision O.3 for specific information. These findings by the Monitoring Team are consistent with the low compliance rates reported by the Facility in its self-assessment. Furthermore, as reported in Provision M3, the following issues were noted: • Four of eight (50%) individuals' risk ratings completed on the revised IRRF format showed some progressive improvement from the previous format used. None of the four IRRFs (0%) included a summary of risk related diagnoses and conditions that were to be completed by the individual's physician. The substantive content of the clinical data used to determine risk ratings for the six risk groups showed improvement. However, the risk factors within a category and between categories needs more improvement in identifying their interrelatedness when determining risk ratings. • Three of nine (33%) individuals' records had Risk Action Plans. None were completed on the revised IHCP format. Individual #115 who was admitted on 3/18/13 did not have an IHCP completed. Individual #108 did not have a current IHCP; the last risk rating was completed on 1/26/12 on the previously used risk rating form. This was a significant finding which would appear that only three of nine (33%) individuals had a plan of care, or else the plans were not put into their records and/or provided for review as requested. The Monitoring Team observed the ISP meetings that were held during the week of the review. Meetings generally included appropriate disciplines; however, the Monitoring Team did not observe use of the required Risk Level Guidelines in any of the meetings.	

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		Additionally, the use of clinical data in discussing risk and determining risk level assignment was variable. For example, during the ISP annual planning meeting for Individual #134 some clinical data was used, and for Individual #118 considerable clinical data was used. Staff present at the ISPs included the actual staff who worked directly with the individual. The individual was present at the meetings. This Provision was 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.	The Monitoring Team reviewed the records of 12 individuals to determine if appropriate risk assessment activity had taken place and was documented. These included Individuals #35, #108, #40, #55, #98, #101, #114, #5, #66, #47, #11 and #79. The records of these 12 individuals were reviewed to determine if changes in circumstance should have resulted in changes to an at-risk assessment, rating, and plan. There were examples of risk events or changes in status. There was documentation that the 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 two individuals (17%), Individuals #35 and #108. Interdisciplinary assessments were generally comprehensive (irrespective of timeliness). In two (Individuals #101 and #40) they were not (17%). Based on a review of records of nine individuals (Individuals #55, #98, #101, #114, #5, #66, #47, #11 and #79) for 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. Improvement was noted from that observed during the last review but each assessment lacked one or more essential components to sufficiently address identified high risk conditions. Based on a review of records of three individuals (Individuals #35, #108, and #40) for whom assessments had been completed to address the individuals' at risk conditions, two (66%) included an adequate PNM assessment to assist the team in developing an appropriate plan. Individual #108 had returned from the hospital following aspiration pneumonia, and risk review did not occur until the scheduled annual ISP. For six individuals in Sample 0.1 for whom the IDT identified changes needed to be made to the PNMP, ISPA meeting documentation noted for two (33%) that the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. For	Noncompliance

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		example: Individuals #40, #35, and #143 had risk levels that needed to be updated based on the IRRF or IDT discussion but this was not evident on the PNMP. 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 and/or risk action plans. Examples are reported in Provisions M.1 and O.2 of this report. 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.	The Monitoring Team reviewed the records of 12 individuals to determine if appropriate risk assessment activity had taken place and was documented. These included Individuals #35, #108, #40, #55, #98, #101, #114, #5, #66, #47, #11 and #79. There was documentation that the Facility: • Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate in two of the 12 (17%) cases (Individuals #35 and #108). • Implemented a plan within 14 days that met the needs identified by the IDT assessment in two of the 12 (17%) cases (Individuals #35 and #108). • Included preventative interventions in the plan to minimize the condition of risk in two of 12 (17%) cases (Individuals #35 and #108). • When risk to the individual warranted immediate action, the Facility took immediate action in two of 12 (17%) cases (Individuals #35 and #108) and integrated the plans into the ISPs in one (9%). • One (9%) of the risk plans documented adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. This was the case for Individual #35. • None documented appropriate functional and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. • One (9%) documented the clinical indicators to be monitored and the frequency of monitoring. This was the case for Individual #108. This Provision is not in substantial compliance.	Noncompliance

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

1. Conduct a thorough review of RGSC SOP MR 400-02 At Risk Individuals and RGSC SOP NR-400-45 At Risk Patient/Individuals to ensure requirements in each policy are consistent with one another and consistent with State policy (Provision I.1).
2. Assure all IDTs are provided with training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the 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 especially with regard to the use of clinical data in determining risk level assignments (Provisions I.1, I.2, and I.3).

3. 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).
4. Ensure that timely implementation of risk remediation plans related to the ISP/ISPAs (primarily IHCPs and PNMT plans) occurs (Provisions I.2 and I.3).

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSS Action Plan, 4/25/2013 2. RGGS Self-Assessment 4/29/2013 3. RGSS Presentation Book, 5/2013 4. RGGS Policy: Integration of Psychology and Psychiatry (no number/no date) 5. RGSC SOP ICF-IID 400-16 Premedication for Medical and Dental Procedures (8/12) 6. Copy of medical license for psychiatrists 7. Copy of CV for psychiatrists 8. Copy of meeting schedule for the psychiatrist-psychologist integration meetings 9. Copy of the past six months polypharmacy committee meeting minutes (February 19, March 26, April 26, and May 13, 2013) 10. Appendix B of the Settlement Agreement 11. Most recent psychiatric assessments, medication evaluation, PBSP data for Individuals #55, #27, #59, #4, #33, #63, #149, #140, #2, and #79 12. Sign in record for IDT associated with the most recent psychiatric assessments for Individuals #55, #27, #59, #4, #33, #63, #149, #140, #2, and #79 13. Reiss screens all new admissions, and for any new psychiatric referral, during the past six months 14. Data, graphs, and analysis of polypharmacy data, for the past six months **People Interviewed:** 1. Dr. David Moron, MD (Clinical Director) 2. Dr. Donald Weather, MD (Psychiatrist) 3. Gary Sauceta (Information Specialist) **Meeting Attended/Observations:** 1. Polypharmacy subcommittee meeting, May 2013
	Facility Self-Assessment: The Monitoring Team was pleased to see that the Facility had begun utilizing data outcome measures for its self-assessment process. A consistent finding throughout the self-assessment was the lack of evidence indicating that the Facility assessed the quality of the indicators being assessed. For example, the assessments for J.2, J.3, J.9, J.10, and J.11, indicated that the Facility completed data analysis, and positive behavioral support plans, however, there was no assessment as to the efficacy, or clinical relevance of the data analysis, and positive behavioral support plans. Furthermore, when the Facility determined substantial compliance, the self-assessment did not evaluate all requirements of the provision. For example, the Facility self-assessment for J.4, indicated that the Facility had developed and implemented a process to help minimize the use of pre-treatment sedation; and in this case, the self-assessment did not evaluate the efficacy of the process, and did not assess all components of the provision, by only commenting on its dental desensitization program. The Provision clearly requires that a multidisciplinary approach be taken for all indications of pre-treatment sedation. For Provision J.12, the Facility did not fully

	assess all requirements of the Provision, and did not assess if side effect rating scales were fully completed by examiner, and if such assessments were completed when clinically necessary. In some instances, such as for Provision J.7, and J.8, the self-assessment did not indicate an actual review of data, but indicated that the Provision was in substantial compliance because "according to the BCBA"; while this may be fact, the self-assessment should consistently evaluate data, and not statements by staff.
	Summary of Monitor's Assessment: The Facility has continued to make progress with Section J, of the Settlement Agreement, and is in substantial compliance with Provisions J1, J2, J5, J6, J7, and J12 The Monitoring Team was impressed with the Facility's initial development and implementation of a polypharmacy committee, and with the comprehensiveness of the new psychiatric assessment process, that ensures a multidisciplinary, comprehensive assessment of individuals who are prescribed a psychotropic medication. The psychiatric assessments incorporate reasonable behavioral data into the diagnostic formulations, and explore the biological, social, psychological, spiritual, and environmental impact on behaviors, as well as utilizing DSM-IVR criteria to formulate psychiatric diagnosis. Substantial compliance, however, will require the Facility to continue to improve in the areas covered by Provisions J3, J4, J8, J9, J10, J11, J13, J14, and J15, by developing a more robust consent process for psychiatric medication use; ensuring close monitoring of side effects from psychotropic medications; developing a process to help reduce the need for the use of pre-treatment sedation; and ensuring that there is an IDT review that explores the risks, benefits, and alternative treatments prior to starting a new non-emergency psychotropic medication,. The following highlights some important issues for each of the 15 Provisions: **Provision J1:** The Monitoring Team identified that the Facility had qualified professionals for the provision of psychiatric services, and therefore the Facility remains in substantial compliance for Provision J.1. **Provision J2:** The Monitoring Team continues to be impressed by the comprehensive review of the clinical data reviewed by the treating psychiatrist, and noted that psychotropic medication management was carefully reviewed by a board certified or board eligible psychiatrist prior to administering of psychotropic medication; therefore, the Monitoring Team determined that the Facility continues substantial compliance for Provision J.2. **Provision J3:** The Monitoring Team determined that there was progress for Provision J3, because the psychiatrist incorporated reasonable behavior data when developing a treatment plan, developed a reasonable bio-psycho-social clinical hypothesis, utilized DSM criteria when developing a psychiatric diagnosis, and because there was no evidence of utilizing psychiatric medication as a punishment. However, it remained unclear that behavioral programs were of adequate quality to ensure psychotropic medications were not used as a substitute for a treatment program. **Provision J4:** The Monitoring Team determined that the Facility was not in compliance with Provision J.4, of the Settlement Agreement. Substantial Compliance will require the Facility to develop an interdisciplinary process that includes the pharmacists, psychologists, psychiatrist, and medical services, to

	help reduce or mitigate the use of pre-treatment sedation for all individuals who are routinely provided pre-treatment sedation for clinical services. Such a process did not exist at the Facility. **Provision J5:** The Monitoring Team determined that the Facility remained in substantial compliance with Provision J.5 because it employed qualified professionals for the provision of psychiatric services, and demonstrated a sufficient number of psychiatrists to provide direct care and oversight of psychiatric services. **Provision J6:** Because the treating psychiatrist adhered to Appendix B, when completing psychiatric assessments, by including the review of appropriate behavioral data; developed a meaningful bio-psycho-social-spiritual assessment, and relied on DSM-IVR criteria, the Monitoring Team will continue substantial compliance for Provision J.6. **Provision J7:** The Facility continues substantial compliance with Provision J.7, because it effectively provided the use of the Reiss screen for all new admissions to the Facility, conducted psychiatric assessment in accordance with Appendix B of the Settlement Agreement for all new admissions, and performed a Reiss screen on all individuals referred to the psychiatrist for psychiatric assessment. **Provision J8:** The Facility demonstrated the incorporation of behavioral data into the psychiatric assessments; meetings and psychiatric documentation provided evidence to support meaningful collaboration among the psychiatrist and psychologist in developing treatment plans. However, psychological and behavioral assessments and PBSPs did not provide evidence of combined assessment and case formulation. Therefore, although progress is clear, the Facility did not yet demonstrate substantial compliance with this provision. **Provision J9:** The Monitoring Team was pleased to see the improved collaborative efforts among psychologists, and psychiatrists at the Facility. To achieve substantial compliance, the Facility needs to document clearly the role of the IDT in addressing these issues. **Provision J10:** The Monitoring Team disagrees with the Facility's self-assessment and determined that the Facility is not in compliance with Provision J10. The Facility must ensure, and provide evidence, that before initiating a new psychotropic medication, the IDT conducted a review, and that the psychologist, psychiatrist, nurse, and primary care physician discussed the risks and benefits of starting the new drug, and if reasonable alternative strategies would be beneficial. **Provision J11:** The Monitoring Team compliments the Facility on its initial development of the polypharmacy committee. It was clear to the Monitoring Team that the level of professional involvement and review of individual cases was exemplary. Substantial compliance will require the Facility to continue development of the process, and ensure that all individuals who are prescribed polypharmacy are reviewed at least quarterly; action plans with associated time frames for completion are developed for relevant issues discussed at the committee; and that the committee reviews a system level review of polypharmacy, utilizing data, and trends analysis, to develop methods to reduce the use of polypharmacy at the Facility.

	Provision J12: Because the Facility completes side effect monitoring for individuals who are provided neuroleptics routinely, and when clinically necessary, and because assessment forms were completed as necessary, the Monitoring Team determined that the Facility was compliant with Provision J.12. **Provision J13:** The Monitoring Team determined that the Facility was not in compliance with Provision J13. Although the sample reviewed indicated that psychiatric treatment plans were conducted as part of an IDT process, and included a clinically justifiable diagnosis, expected timelines for therapeutic effect of medications, and what parameter would be used to assess efficacy, the Structural and Functional Analyses did not reflect that target symptom identification procedures were included. **Provision J14:** The Facility was not in compliance at the last Monitoring Team review, and the clinical director informed the Monitoring Team that it had not developed or implemented a new consent process. The Monitoring Team continued a finding of noncompliance for Provision J14, and encourages the Facility to develop a new consent process that will lead to substantial compliance. **Provision J15:** The clinical director informed the Monitoring Team that the Facility did not have a process to ensure an IDT collaboration between the psychiatrist and neurologist when medications were prescribed to treat both a neurological and psychiatric condition. The Facility remained in noncompliance for Provision J15. The Monitoring Team encourages the Facility to develop a process that will lead to substantial compliance, as soon as possible.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	To assess compliance with Provision J1, the Monitoring Team reviewed the copies of the medical licenses, and C.Vs of the practicing psychiatrists. The Facility reported having three psychiatrists who provided coverage for psychiatry at the Facility: • Three out of three (100%) had current medical licenses. • One out of three (33%) was board certified in psychiatry, and two out of three (66%) were board eligible, based on review of their CV. • Three out of three (100%) demonstrated maintenance of CME credits • There was no evidence to indicate that the Facility provided specific CME opportunities for the practice of ID/DD psychiatry. Summary: The Monitoring Team identified that the Facility had qualified professionals for the provision of psychiatric services, and therefore the Facility remains in substantial compliance for J1. The Monitoring Team recommends that psychiatrists are provided CME opportunities specific to ID/DD psychiatric practice.	Substantial Compliance

J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	To assess compliance for Provision J2, the Monitoring Team reviewed the most recent annual psychiatric assessments, current positive behavioral support plan (PBSP) data, psychotropic medication list, and most recent psychiatric medication evaluation, for the first ten individuals on a list of all individuals who were currently prescribed a psychotropic medication (Individuals #55, #27, #59, #4, #33, #63, #149, #140, #2, and #79): • Ten out of ten (100%) individuals reviewed were evaluated by a board certified, or board eligible psychiatrist, prior to the prescribing and administration of a psychotropic medication. • Ten out of ten (100%) individuals reviewed were assessed. • Ten out of ten (100%) of the psychiatric assessments reviewed included a comprehensive review of appropriate behavior data. • Ten out of ten (100%) of the psychiatric assessments included a comprehensive mental status examination. • Ten out of ten (100%) of the psychiatric assessments include a justifiable psychiatric diagnosis, based on DSM-IVR criteria. Summary: The Monitoring Team continues to be impressed by the comprehensive review of the clinical data reviewed by the treating psychiatrist, and noted that psychotropic medication management was carefully reviewed by a board certified or board eligible psychiatrist prior to administering of psychotropic medication; therefore, the Monitoring Team determined that the Facility continues substantial compliance for Provision J.2.	Substantial Compliance
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	To assess compliance for Provision J3, the Monitoring Team reviewed the most recent annual psychiatric assessments, current positive behavioral support plan (PBSP) data, psychotropic medication list, and most recent psychiatric medication evaluation, for the first ten individuals on a list of all individuals who were currently prescribed a psychotropic medication (Individuals #55, #27, #59, #4, #33, #63, #149, #140, #2, and #79): • Of the ten annual psychiatric assessments review, ten out of ten (100%) indicated an integration of behavioral data into the psychiatric assessment by the psychiatrist. • Ten out of ten psychiatric assessments (100%) utilized DSM-IVR criteria when developing a psychiatric diagnosis. • There was no evidence to indicated that psychotropic medications were used as a form of punishment, in ten out of the ten (100%) psychiatric assessments reviewed. • In ten out of ten (100%) psychiatric assessments, the psychiatrist developed a clinically justifiable bio-psycho-social assessment when developing the treatment plan.	Noncompliance

		Three individuals received chemical restraints. For two (67%), the clinical review conducted by the pharmacist and psychiatrist was sufficiently detailed to determine whether the chemical restraint was used in a clinically justified manner; that medication related risks were considered prior to the use of the chemical restraint; of the apparent effectiveness of the chemical restraint in reducing the dangerous behavior in the hours after administration; and that relevant recommendations were made by the pharmacist and the psychologist. This information was correctly documented on the Chemical Restraint Consult Form and was signed by the pharmacist and the psychiatrist. An example where this review did not occur was restraint of Individual #77. However, as reported in Section K, there were difficulties in the provision of behavioral interventions that put into question whether adequate treatment programs were in place that could minimize the use of psychotropic medications. Provision K5 reported that formal behavioral assessments did not consistently address whether some mental illness symptoms were due in part to environmental conditions or could be treated through behavioral procedures. Provision K9 reported that behavioral interventions did not yet include all necessary components, although progress had continued. Summary: The Monitoring Team determined that the Facility continued to progress toward substantial compliance for Provision J3, because the psychiatrist incorporated reasonable behavior data when developing a treatment plan, developed a reasonable bio-psycho-social clinical hypothesis, utilized DSM criteria when developing a psychiatric diagnosis, and because there was no evidence of utilizing psychiatric medication as a punishment. To achieve substantial compliance, the Facility will need to demonstrate that behavioral interventions are of sufficient quality to ensure that psychotropic medications are not used as a substitute for adequate behavioral treatment programs.	
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	To assess the Facility's ability to develop a process to help eliminate the need for pre-treatment sedation, the Monitoring Team requested copies of relevant policies and procedures, data and trends analysis for the use of oral pre-treatment sedation, committee meeting minutes documenting review of pre-treatment oral sedation, and clinical data relevant to assessing pre-treatment sedation. The RGSS central office staff informed the Monitoring Team that the Facility did not have documentation, as requested. The Facility reported no use of planned pre-treatment sedation for medical or dental procedures or any use of TIVA for dental procedures. Furthermore, during the Monitoring Team's discussion for dental services with Lorraine Hinrichs (ICF- DD Director), Ms. Hinrichs informed the Monitoring Team that the Facility did not have a process to help reduce the need for pre-treatment sedation, other then the dental rehearsal program.	Noncompliance

	psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	Although the Facility provides a dental rehearsal program to help reduce the need for sedation during dental procedures, the Monitoring Team determined that because of the infrequent opportunities offered for dental rehearsals, the program was unlikely to be effective. The Facility must enhance opportunities to help individuals better accommodate to dental services. RGSC SOP ICF-IID 400-16 Premedication for Medical and Dental Procedures, revised in August 2012, governs pre-treatment sedation. Although it requires the IDT to "discuss alternative (sic) to premedication (using form Alternatives to Premedication as a guide)" and requires the discussion and recommendations to be documented, it does not require a plan to minimize the need for pre-treatment sedation. Summary: The Monitoring Team determined that the Facility was not in compliance with Provision J4. Substantial Compliance will require the Facility to develop an interdisciplinary process that includes the pharmacists, psychiatrist, and medical services, to help reduce or mitigate the use of pre-treatment sedation for all individuals who are routinely provided pre-treatment sedation for clinical services. Such a process did not exist at the Facility.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	To assess compliance with Provision J1, the Monitoring Team reviewed the copies of the medical licenses, and C.Vs of the practicing psychiatrists. The Facility reported having three psychiatrists who provided coverage for psychiatry at the Facility: • One, full-time board eligible psychiatrist (Board Certification expired on 2012) • One, part-time board eligible psychiatrist • One, full-time board certified psychiatrist who serve as the clinical director, and provides direct psychiatric care • Three out of three (100%) had current medical licenses • One out of three (33%) was board certified in psychiatry, and two out of three (66%) were board eligible, based on review of their CV • Three out of three (100%) demonstrated maintenance of CME credits The Facility ensured that one full time equivalent locum psychiatrist was available to provide direct clinical care of the 38 individuals who were prescribed psychotropic medications. The Clinical Director provides approximately 25% time of direct clinical care, as oversees the clinical care provided by the locum psychiatrist. When implementing a new process, the Facility added a part-time locum psychiatrist to help ensure the implementation of new any new practice.	Substantial Compliance

		Summary: The Monitoring Team determined that the Facility remained in substantial compliance with Provision J.5 because it employee qualified professionals for the provision of psychiatric services, and demonstrated a sufficient number of psychiatrist to provide direct care, and oversight of psychiatric services.	
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.	To assess compliance for Provision J6, the Monitoring Team reviewed the most recent annual psychiatric assessments, current positive behavioral support plan (PBSP) data, psychotropic medication list, and most recent psychiatric medication evaluation, for the first ten individuals on a list of all individuals who were currently prescribed a psychotropic medication (Individuals #55, #27, #59, #4, #33, #63, #149, #140, #2, and #79): Ten out of ten psychiatric assessment (100%) adhered to Appendix B, of the Settlement Agreement. • Ten out of ten (100%) individuals reviewed were evaluated by a board certified, or board eligible psychiatrist, prior to the prescribing and administration of a psychotropic medication. • Ten out of ten (100%) individuals reviewed had a psychiatric assessment that followed the format of Appendix B, of the SA. • Ten out of ten (100%) of the psychiatric assessments reviewed included a comprehensive review of appropriate behavior data. • Ten out of ten (100%) of the psychiatric assessments included a comprehensive mental status examination. • Ten out of ten (100%) of the psychiatric assessments include a justifiable psychiatric diagnosis, based on DSM-IVR criteria. Summary: Because the treating psychiatrist adhered to Appendix B, when completing psychiatric assessments, by including the review of appropriate behavioral data; developed a meaningful bio-psycho-social-spiritual assessment, and relied on DSM-IVR criteria, the Monitoring Team will continue substantial compliance for Provision J.6.	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,	To assess if the Facility completes a Reiss screen on all new admissions, and when a new psychiatric condition is being evaluated, the Monitoring Team requested a list of all individuals who were referred to the psychiatrist for assessment of a new behavioral issue, and a list of all new admissions to the Facility, along with a copy of the Reiss assessment tool: The Facility reported one individual being referred to the psychiatrist, during the reporting period, and in the one out of one case (100%), a Reiss screen was completed.	Substantial Compliance

	and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	In addition, a psychiatric evaluation was provided. The Facility reported three new admissions to the Facility (Individuals #119, #114, and #115). Of the three new admissions, there was evidence that a Reiss screen had been completed in three out of three cases (100%). In addition, all three (100%) had a psychiatric evaluation. Summary: The Facility continues substantial compliance with Provision J.7, because it effectively provided the use of the Reiss screen for all new admissions to the Facility, conducted psychiatric assessment in accordance with Appendix B of the Settlement Agreement for all new admissions, and performed a Reiss screen on all individuals referred to the psychiatrist for psychiatric assessment.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	To assess if the Facility integrates pharmacological treatments with behavioral and other interventions, through a combined assessment and case formulation, the Monitoring Team reviewed the Facility's policy entitled Integration of Psychology and Psychiatry (no number/no date), a copy of the schedule documenting meetings among the psychologist and psychiatrist, behavioral support data, and psychiatric assessments for the first ten individuals on a list of all individuals who were prescribed a psychotropic medication. The Monitoring Team noted that the psychiatrist and psychologist met weekly to review and assess the integration of non-psychotropic therapies with psychotropic therapy. By review of the most recent psychiatric assessments that were reviewed as part of the meeting with the psychiatrist and psychologist, for Individuals #55, #27, #59, #4, #33, #63, #149, #140, #2, and #79, the Monitoring Team noted review and incorporation of behavioral data into the psychiatric assessments. Each psychiatric assessment included a review of both the psychotropic and behavioral impact on the individuals. This excellent process moves the Facility closer to substantial compliance with this provision. However, the meetings and review will need to involve more evidence of substantive combined assessment and case formulation. Although there was evidence in the psychiatric assessments of review of both psychotropic and behavioral impact, there was little found in the Structural and Functional Assessments (SFAs) and PBSPs to reflect this. There was very little about assessments or data regarding psychiatric symptoms or behavioral correlates. It was not clear in the psychology documents what has been presented to the psychiatrist or how behavior data were used by the psychiatrist. In other words, even though it sounds from psychiatry that a reasonable practice is in place, nothing that psychology incorporates reflected that. Summary	Noncompliance

		The Facility demonstrated the incorporation of behavioral data into the psychiatric assessments; meetings and psychiatric documentation provided evidence to support meaningful collaboration among the psychiatrist and psychologist in developing treatment plans. However, psychological and behavioral assessments and PBSPs did not provide evidence of combined assessment and case formulation. Therefore, although progress is clear, the Facility did not yet demonstrate substantial compliance with this provision.	
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 assess if the Facility conducts an IDT process that considers the least intrusive and most positive interventions to treat behavioral or psychiatric conditions, and whether the individual would be best served through a behavioral, pharmacological, or combined treatment approach, and to ensure that individuals prescribed psychotropic medications had non-pharmacological interventions and supports to help reduce the need for psychotropic medications, the Monitoring Team reviewed the schedule of the combined psychology-psychiatry meeting to integrated behavioral therapy and pharmacological therapy; and for the ten most recent cases assessed by the combined psychology and psychiatry meeting (Individuals #55, #27, #59, #4, #33, #63, #149, #140, #2, and #79), copies of the most recent psychiatric assessment, current behavioral data, and current psychotropic medication list for individuals. The Clinical Director informed the Monitoring Team that relevant staff and LARs are invited to participate in the psychiatric assessment process and discussions, which is in addition to the weekly meetings between the psychiatrist and psychologist. Facility policy requires this involvement. Sign-in sheets document the staff in attendance. The psychiatric assessment form has a specific section outlining the psychiatrist and psychologist review of various proposed therapies. In ten out of ten cases reviewed (100%), there was documented evidence that the quarterly psychotropic meetings took place in the context of a IDT meeting, as evidenced by each case being accompanied by a sign-in sheet, that demonstrated a multidiscipline approach, and included case manager, psychologist, psychiatrist, unit nurse, direct care staff member, among others. Although the Monitoring Team did not observe a meeting at this compliance visit, observation at prior compliance visits verified the interdisciplinary nature of the discussion and the involvement of IDT members in decision-making. In ten out of ten cases (100%), there was documentation that the psychologist and psychiatrist reviewed and collaborated on developing treatment for the use of behavioral interventions, psychotropic interventions, or a combination of therapies. In ten out of ten cases (100%), there was documentation that the psychiatrist, in collaboration with the psychologist, reviewed behavioral data.	Noncompliance

		In ten out of ten cases (100%), there was documentation that the psychiatrist, in collaboration with the psychologist reviewed biological, psychological, social, environments, and spiritual factors, when developing a treatment plan. Nevertheless, as noted below, it was not clear that the substantive discussion leading to these decisions was reflected in the assessments carried out by psychology, nor that structured behavioral assessments had been used to provide adequate information on the possible influence of environmental conditions. In ten out of ten cases (100%), there was documentation that the psychiatrist, in collaboration with the psychologist determined the least intrusive therapy by reviewing the risks and benefits of pharmacological and behavioral therapy. In ten out of ten cases (100%), there was documented evidence to indicate that behavioral interventions were in place to help reduce the ongoing need for psychotropic medication. However, as reported in Provision K5, the Structural and Functional Assessments (SFAs) did not demonstrate consideration of information from the extensive assessments provided by the psychiatrist of psychopathology in individuals prescribed psychotropic medication (which included subjective and objective information and resulted in a finding of Substantial Compliance for Provision J6). All of the reviewed SFAs did include some discussion of potential symptoms of mental illness and the pharmacologic treatment of those symptoms. Moreover, there was little evidence to suggest that a formal behavioral assessment had been used to identify whether some mental illness symptoms were due in part to environmental conditions or could be treated through behavioral procedures. This would have been useful information in making determinations of the appropriate treatment. To facilitate determination of the least restrictive and most positive interventions and development of successful and relevant PBSPs as part of a comprehensive treatment program, all information should be considered in making determinations and in developing the interventions. Summary: The Monitoring Team was pleased to see the improved collaborative efforts among psychologists, and psychiatrists at the Facility. The Facility is very close to substantial compliance with this provision. To achieve substantial compliance, the Facility needs to ensure ISPs and PBSPs demonstrate that information from assessments is used across disciplines and determinations of the least intrusive and most positive interventions are evident in and consistent across psychiatric and behavioral treatments. Decisions about treatment must carry over to al areas of psychiatric and behavioral conditions being addressed.	
J10	Commencing within six months of the Effective Date hereof and with	To determine if the Facility conducted a comprehensive IDT review that included the psychiatrist, nurse, psychologist, and primary care physician, before initiating a new	Noncompliance

	full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	psychotropic medication, the Monitoring Team requested that the most recent psychiatric medication evaluation, and copy of relevant ISPs for the last ten individuals who had a new psychotropic medication added. The Monitoring team was provided with ISPs, quarterly psychiatric medication evaluations, and the most recent psychiatric assessments for Individuals #55, #27, #51, #4, #33, #63, #149, #140, #75, and #79. Following review of all supporting documents, the Monitoring Team could not identify evidence to indicate that before starting a non-emergency psychotropic medication that an IDT review was held and included a review by all relevant staff, including the nurse, and primary care physician, and discussed the risks and benefits of starting the new drug, and if reasonable alternative strategies would be beneficial; however, the Monitoring Team did determine that the psychiatrist and psychologist discussed relevant details regarding initiation of starting a new psychotropic medication. The Monitoring Team disagrees with the Facility's self-assessment and determined that the Facility is not in compliance with Provision J10. The Facility must ensure, and provide evidence, that before initiating a new psychotropic medication, the Facility conducted an IDT review, and that the psychologist, psychiatrist, nurse, and primary care physician discussed the risks and benefits of starting the new drug, and if reasonable alternative strategies would be beneficial.	
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 if the Facility provided a mechanism that includes a system review of the use of polypharmacy at the Facility, the Monitoring Team attended the Facility's polypharmacy meeting, reviewed the procedure for the polypharmacy meeting, and requested that last six months of the polypharmacy committee minutes, including all data, graphs, and data analysis. Through review the of psychiatric polypharmacy committee procedure, the Monitoring Team noted that there was no process to ensure that there was a systems review for the use of polypharmacy. Also, there was no process to ensure that all individuals who were prescribed psychotropic polypharmacy were reviewed at least quarterly. The polypharmacy committee meeting that was attended by the Monitoring Team demonstrated a comprehensive review of the two Individuals reviewed at the meeting. It was evident that the committee members, explored the risks and benefits of polypharmacy for the individuals whose cases were reviewed. There was no evidence that a system wide review of polypharmacy was done. The nurse member of the committee informed the Monitoring Team that since the committee had just recently started, they had not yet determined what data elements they would use for a future systems review and analysis. Review of the past six months polypharmacy meeting minutes indicated that there were	Noncompliance

		a total of four meetings, that took place since the committee started in February, 2013 (February 19, March 26, April 26, and May 13, 2013). Review of the minutes demonstrated excellent review of clinical issues associated with individual cases of polypharmacy. The Monitoring Team noted that there were no formal action plans and associated assignment of a responsible person to ensure development and implementation, nor was there follow-up on the action plan, or a specific timeframe when a action plan should be completed or reviewed. For example, in the April 23, 2013 minutes, there was a discussion that "all medications should reconcile with the medical records and everything should match CWS" and "patients should have EKG and be monitored for any mood or behavior changes". There was no plan to address these concerns, and to assess if all medication did in fact reconcile with the medical records and CWS. The March 26, 2013 minutes documented that "charts will be audited on a monthly basis to see if anything has changed", and there was no associated action plan or responsible person. The May 13, 2013 minutes documented that "Dr. Moron requested that the work group create a high risk poly-pharmacy group so that these individuals are periodically reviewed", but there was no responsible person assigned, no specific action plan developed, and no completion date stated. Such examples were pervasive throughout the minutes reviewed. Also, the minutes did not reflect on a review of system wide data, trends analysis and action plan to reduce polypharmacy from a systems perspective. Summary: The Monitoring Team compliments the Facility on its initial development of the polypharmacy committee. It was clear to the Monitoring Team that the level of professional involvement and review of individual cases was exemplary. Substantial compliance will require the Facility to continue development of the process, and ensure that all individuals who are prescribed polypharmacy are reviewed at least quarterly; action plans with associated time frames for completion are developed for relevant issues discussed at the committee; and that the committee reviews a system level review of polypharmacy, utilizing data and trends analysis, to develop methods to reduce the use of polypharmacy at the Facility.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least	To assess if the Facility monitors side effects, including Tardive Dyskinesia, for Individuals receiving neuroleptic medication, the Monitoring Team requested an alpha list of all Individuals who were prescribed a new antipsychotic medication, and an alpha list of all Individuals who had a dose increased of their prescribed neuroleptic medication, within the past six months, and all associated MOSES and DISCUS reports, for the first ten individuals on the lists. The completed document request noted that no Individuals were prescribed a new neuroleptic, and only five individuals were prescribed dose increase for the previously prescribed neuroleptic. Of the six Individuals who were prescribed a dose increase in their neuroleptic (#81,	Substantial Compliance

	quarterly.	#77, #139, #46, #63, #84), a total of 11 MOSES, and 11 DISCUS assessment forms were provided for review. • Of the 11 MOSES assessment forms, the examiner component was fully completed in 9 of the 11 samples (82%). • Of the 11 DISCUS assessment forms, the examiner component was fully completed in 9 of the 11 samples (82%). • Of the 11 MOSES assessment forms, the prescriber component was fully completed in ten out of 11 samples (91%). • Of the 11 DISCUS assessment forms, the prescriber component was fully completed in ten out of 11 samples (91%). • Of the 22 assessment forms provided for review, 22 out of 22 (100%) were signed by the physician within seven days from the date of the assessment. • Of the six individuals who were provided an increased dose of a neuroleptic, five of the six (83%) were provided more frequent monitoring of side effects by completion of at least one additional MOSES and DISCUS assessment, following the dose increase. • Of the six individuals who were provided an increased dose of a neuroleptic, six out of six (100%) were provided routine screening for side effects of neuroleptics, within the past six month period. Summary The Monitoring Team compliments the Facility for enhancing its monitoring of side effects of individuals who were prescribed neuroleptic medication. The Monitoring Team noted that all six individuals were provided enhanced monitoring by means of both the DISCUS and MOSES assessments, following a dose increase of a neuroleptic. Also, the Facility ensured that MOSES and DISCUS assessments were completed routinely, and assessment forms were reviewed and signed by the prescriber within seven days from the date of the assessment.	
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	To assess if psychiatric treatment plans were conducted as part of an IDT review, and included a clinically justifiable diagnosis, expected timelines for therapeutic effect of medications, and what parameter would be used to assess efficacy, the Monitoring Team utilized the sample selection as for Provision J.2, (Individuals #55, #27, #59, #4, #33, #63, #149, #140, #2, and #79): • Of the ten samples, ten out of ten (100%) included timelines for expected therapeutic effect of psychotropic medications. • The psychiatric assessments were conducted as part of an IDT meeting, in ten out of ten (100%) cases. • Ten out of ten (100%) indicated that the psychiatrist at the quarterly psychiatric medication evaluation would assess therapeutic affects of medications. • Ten out of ten (100%) cases included incorporation of psychological, spiritual,	Noncompliance

	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.	biological, and environmental factors into the development of a diagnostic hypothesis, and treatment plan. • Ten out of ten (100%) treatment plans had identifiable behavioral symptoms to monitor for diagnostic and treatment efficacy. However, although the information from this sample would indicate that identifiable behavioral symptoms were included in psychiatric treatment plans, they were not clearly identified in Structural and Functional Assessments, as reported in Provision K5. Summary: Based on the document review, the Monitoring Team determined that the Facility was not in compliance with Provision J13. Although the sample reviewed indicated that psychiatric treatment plans were conducted as part of an IDT process, and included a clinically justifiable diagnosis, expected timelines for therapeutic effect of medications, and what parameter would be used to assess efficacy, the Structural and Functional Analyses did not reflect that target symptom identification procedures were included.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	To assess the consent process for psychotropic medications, the clinical director informed the Monitoring Team that it had not enhanced the consent process since the last Monitoring Team Review, and based on review of the Settlement Agreement, determined that the Facility was not in compliance. While on-site, the Monitoring Team reviewed a blank copy of the current consent form and noted that it was the same consent process from previous reviews, and did not address alternative treatments, time-lines for expected efficacy, and non-FDA indication. Summary: Because the Facility was not in compliance at the last Monitoring Team review, and the clinical director informed the Monitoring Team that it had not developed or implemented a new consent process, the Monitoring Team continued noncompliance for Provision J.14, and encourages the Facility to develop a new consent process that will lead to substantial compliance.	Noncompliance
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.	Upon reviewing if the Facility coordinated between the psychiatrist and neurologist when medications were prescribed to treat both a neurological and psychiatric condition, the clinical director informed the Monitoring Team that they not been able to develop an effective process to address Provision J.15, but will continue to work with the neurologist to ensure that this process be developed in the near future. Summary: Because the clinical director informed the Monitoring Team that the Facility did not have a process to ensure an IDT collaboration between the psychiatrist and neurologist when medications were prescribed to treat both a neurological and psychiatric condition the	Noncompliance

		Monitoring Team determined noncompliance for Provision J.15, of the Settlement Agreement. The Monitoring Team encourages the Facility to develop a process that will lead to substantial compliance, as soon as possible.	

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

1. The Monitoring Team recommends that psychiatrists be provided CME opportunities specific to ID/DD psychiatric practice. (Provision N.1)
2. Develop a multidisciplinary, IDT process to help reduce the need for all individuals who are provided with regular pre-treatment sedation at the Facility, external diagnostics, procedures and consultations. (Provision J.4)
3. Develop an IDT process, which is documented as a component of the ISP, assesses the individual prior to starting a new psychotropic medications, and ensures that the risks, benefits, and alternative treatments are considered (Provision J.10)
4. Enhance the polypharmacy committee by tracking and trending polypharmacy use at the Facility, and ensure a systems review, with corrective action plans for systems issue related to polypharmacy, when indicated. (Provision J.11)
5. Ensure that MOSES and DISCUS assessments are fully completed, completed per policy, and more frequently when clinically appropriate. (Provision J.13)
6. Develop and implement a consent form for psychotropic medication use, that documents risks and benefits, alternative treatments, non-FDA use of psychotropic medications, times-lines for expected efficacy, potential contraindications. (Provision J.14)

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Self-Assessment (4/29/2013) 2. RGSC Action Plan (4/25/2013) 3. RGSC May 2013 Presentation notes 4. Minutes for the Peer Review Committee (9/24/2012-2/25/2013) 5. Documents that were reviewed included the annual ISP, ISP updates, Skill Acquisition Programs (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 RGSC Self-Assessment and Action Plan and included Individuals . **People Interviewed:** 1. Ruben Nieto, BCBA – Psychology Director 2. Samantha Salinas, MSW – Contract Associate Psychologist 3. Cheryl Fielding, PhD, BCBA – Contract Psychologist 4. Alonzo Andrews, M.A., BCBA – Contract Psychologist 5. Megan Gianotti, M.Ed., BCBA – Contract Psychologist 6. Direct Support Professionals: Approximately 15 staff members in residences, classrooms and vocational settings **Meetings Attended/Observations:** 1. Peer Review Committee (PBSC) 2. Human Rights Committee (HRC) 3. Observations were conducted in all residences, classrooms, vocational settings, and leisure areas on 5/14, 5/15, and 5/16.
	Facility Self-Assessment: At the time of the site visit, RGSC reported that Provisions K.1, K.2, K.6 and K.7 were in substantial compliance with the SA. The Monitoring Team was in agreement with the Facility concerning Provision K.2. The Monitoring Team was not in agreement with the Facility's assertion that substantial compliance had been achieved for Provisions K.1, K.6, and K.7. Provision K.6 stipulates that Facility will ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data. Provision K.7 stipulates that Facility shall complete psychological assessment(s) of each individual at least annually and as often as needed. In the Self-Assessment, the Facility asserted that all individuals had current intellectual and adaptive skill assessments except for a single new admission. Facility tracking data, however, reflected that two individuals had not been provided with any Psychological Assessment, and that 12 individuals had not been provided with the necessary testing and evaluation reports within the past year. Furthermore, a review of records revealed

	that structural and functional assessments did not adequately address issues relating to mental illness. Based upon information provided by the Facility, the assertions of substantial compliance in Provisions K.6 and K.7 could not be corroborated. Furthermore, discrepancies between the Self-Assessment and Facility data, as well as between Facility data on the same process but from different sources, were common. Because of this, it was often difficult to determine if the Facility could accurately monitor and assess on-going services. Another area of concern in the Self-Assessment was the lack of detail regarding the procedures and tools used for the assessment process. In the Self-Assessment, the Facility frequently reported the documents or items that were reviewed, as well as the sample size and the percentage of the sample that were correct or appropriate. It was typically not stated, however, what criteria, tools, or guidelines were used to establish whether the item, document, or process was satisfactory. In addition, it was not clear that the Facility consistently assessed the issues relevant to the Provision targeted. For example, Provision K.5 requires that the Facility develop and implement assessment procedures that allow for the identification of medical, psychiatric, environmental, and other reasons for behavioral or mental health challenges. This requirement mandates that the procedures be of sufficient quality to allow for accurate assessment. The Self-Assessment, however, focused primarily upon whether specific elements were present rather than if those elements were adequate to the task. RGSC also provided an Action Plan that described the Facility's strategy for meeting substantial compliance with the Settlement Agreement. It was not clear, however, how beneficial the Action Plan might be. The majority of the Action Plan steps focused upon creating or implementing specific procedures, but did not address what would be required to ensure that those procedures were of sufficient quality. Additionally, the majority of steps were listed as either completed or in process with an estimated completion date of 5/31/2013. Establishing broad goals for tasks, some of which would require completion in a sequence, with simultaneous completion dates did not appear practical or helpful to the compliance process. In consideration of the limitations noted in the RGSC Self-Assessment process, findings, and Action Plan, it was unlikely that the Self-Assessment process was sufficient to guide the Facility toward substantial compliance with the Settlement Agreement.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RGSC from 5/12/2013 through 5/17/2013. Record reviews continued off-site for several days following the site visit. Based upon the information gathered, it was determined that RGSC had established substantial compliance with the Settlement Agreement for Provisions K.2, and K.11. RGSC had not sufficiently addressed many areas included in the Settlement Agreement. Furthermore, it appeared likely that the Facility would need to expend considerable time and resources to address those areas in which substantial compliance had not yet been attained.

	In addition to the areas of substantial compliance, RGSC did demonstrate progress in several areas. • The Facility had established and maintained an internal peer review process that reflected several essential components and procedures. • In several records, data presentation and treatment monitoring reflected evidence-based practices. • Several PBSPs reflected behavior analytic practices and were of sufficient quality to make behavior change likely. • Data graphs, other than in relation to interobserver agreement (IOA), were sophisticated and useful. There were also areas in which little progress was evident. • The Facility had not maintained efforts to measure and track IOA and treatment integrity procedures. • Psychological Assessment reports were not provided upon admission. Additionally, not all individuals were provided with Psychological Assessments annually or as often as needed. • The Facility often made use of parallel tracking mechanisms that did not reflect agreement. For example, the Facility had at least two systems for tracking the completion of Psychological Evaluations; the separate systems did not reflect agreement regarding Psychological Evaluations. • SFAs did not fully reflect the findings of psychiatric evaluations and did not adequately addresses behavioral components of mental illness.

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	<u>Historical Perspective</u> 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, shortly after the August 2011 site visit, passed the board certification exam and became a Board Certified Behavior Analyst (BCBA). Prior to the March 2012 site visit, Ms. Gianotti left RGSC. Ms. Gianotti and was replaced by Vanessa Villarreal, M.Ed.; Ms. Villarreal was not a BCBA. During the August 2012 site visit, RGSC had just hired Ruben Nieto, MA as Psychology Director. Mr. Nieto was Board Certified as a behavior analyst. <u>Current Site Visit</u> At the time of the current site visit, Ruben Nieto was the only full-time, regular employee of RGSC who was a BCBA. It was announced during the site visit that a position for a second BCBA had been advertised.	Noncompliance

	3/2010	8/2012	5/2013
Percent of staff who were BCBAs	0%	50%	50%
Percent of staff lacking BCBA who were	0%	0%	0%

#	Provision	Assessment of Status	Compliance
		pursuing board certification | | | | Percent of staff who were BCBAs or were pursuing board certification | 0% | 0% | 0% Although Mr. Nieto was the only full-time BCBA at the Facility, there was evidence to support that all PBSPs had been developed and written by a BCBA. Quality of the PBSPs, as noted in Provision K9, had remained similar to the prior compliance visit, with most required components present but with some areas of weakness. Substantial compliance will require improvement in completion of the components reviewed for quality of PBSPs.	
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, and was board certified as a behavior analyst. Based upon his 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. *"In cases in which withholding or implementing treatment involves potential risk, Peer Review Committees and Human Rights Committees play distinct roles in protecting client welfare. Peer Review Committees, comprised of experts in behavior analysis, impose professional standards to determine the clinical propriety of treatment programs." (The Right to Effective Behavioral Treatment. Van Houten, R. et.al. 1988. Journal of Applied Behavior Analysis, 21, 381-384.* In order to meet these goals, an organization or Facility must ensure that the necessary resources are available, policies and procedures are implemented, and demonstrably competent staff participates. In addition, steps must be taken to ensure that the implementation of peer review does result in interventions that adhere to acceptable practices. <u>Historical Perspective</u> 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		formulating treatment decisions, and a lack of integration between psychology and medical services. During the August 2011 site visit, 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. At the time of the March 2012 site visit the internal peer review process had been revised again. This revision provided additional psychology staff as members of the peer review committee, and included Cheryl Fielding, PhD, BCBA, as Chair. Dr. Fielding was a contractual employee at RGSC. In August 2012, the Facility had only recently begun a revised internal and external peer review process. <u>Current Site Visit</u> At the time of the current site visit, the Positive Behavior Support Peer Review Committee provided internal peer review. RGSC presented documentation that the Positive Behavior Support Peer Review Committee had met 18 of 23 weeks between 9/24/2012 and 2/25/2013. As four of the five missed weeks were accounted for by holidays, it was determined that a reasonable effort toward weekly meetings had been demonstrated. The Positive Behavior Support Peer Review Committee was comprised of four BCBAs (Ruben Nieto, Dr. Cheryl Fielding, Alonzo Andrews, and Megan Gianotti), as well as the two Psychology Assistants (Michelle Melchor and Aurora Reyna). Not more than one of the BCBAs was absent from any of the committee meetings. The Facility reported in the Self-Assessment that 27 PBSPs had been reviewed by the peer review committee between 8/01/2012 and 3/31/2013. The Monthly Report for Completed SFAs, PBSPs and Psychological Evaluations, however, reflected that 31 PBSPs had been approved during that time. A second tracking spreadsheet, the Psychology Interdepartmental Tracking, reflected that 32 PBSPs had been approved during that same period. Due to conflicted documentation, it was not evident that the Facility had adequately monitored the internal peer review of PBSPs. The primary function of the PBSC was the review of new behavior interventions. Between 9/24/2012 and 2/25/2013, peer review minutes revealed there were no reviews of on-going PBSPs or treatment outcomes. Peer review minutes did reflect that the committee at times required revisions to new PBSPs prior to implementation. Due to missing information on the Peer Review Log, however, it was not possible to determine if or how quickly the recommendations were implemented.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Tracking data regarding external peer review reflected that three PBSPs had been provided external peer review since 8/1/2012: The most recent external peer review occurred on 11/5/2012. The Facility indicated in the Self-Assessment that every fifth PBSP was to be provided external peer review. The lowest figure provided by the Facility for internal peer review (27 PBSPs), would indicate that at least five PBSPs should have received external peer review. Furthermore, as at least 16 PBSPs were provided internal peer review since 11/5/2012, at least three of those PBSPs should have been provided external peer review.

Based upon information provided by the Facility, it appeared that internal peer review meetings occurred at least weekly and included adequate BCBA participation. It was not evident, however, that the Facility was adequately monitoring the review process. Neither was it evident that the Facility had provided the necessary external peer review.</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>
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. In August 2012, only a small number of PBSPs had been completed. Although there were some indications of improvement, the sample size was too small to allow for assessment of compliance.

<u>Current Site Visit</u>
Information obtained from record reviews and observations during the current site visit reflected solid improvement in nine of 12 areas of Provision K.4 (75%). This was most notable concerning replacement behavior data collection, replacement behavior graphing, review of PBSPs by a BCBA, and input from direct support staff.

<table>
<tr><th></th><th>3/2010</th><th>8/2012</th><th>5/2013</th></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress</td><td>0%</td><td>0%</td><td>8%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress</td><td>0%</td><td>17%</td><td>75%</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>67%</td><td>92%</td></tr>
<tr><td>Targeted behaviors graphed sufficient for decision-making</td><td>0%</td><td>67%</td><td>100%</td></tr>
<tr><td>Replacement behaviors graphed sufficient</td><td>0%</td><td>0%</td><td>92%</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

for decision-making			
Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level	0 %	67%	33%
Review is conducted by a BCBA	0%	0%	75%
Input from direct care staff is solicited and documented	0%	0%	83%
Modifications to the PBSP reflect data-based decisions	0%	50%	67%
Criteria for revision are included in the PBSP	0%	67%	92%
Progress evident, or program modified in timely manner (3 Months)	0%	33%	75%

Despite areas of improvement, data collection and monitoring at RGSC did not satisfy the requirements of the Settlement Agreement.

- Only one of 12 reviewed PBSPs (8%) reflected adequate data collection for target behaviors. In the majority of PBSPs, data collection instructions stated that data should be collected as soon as possible and at least by the end of the shift. To ensure that data are valid and reliable, it is essential that data be recorded as near in time as possible to the display of the behavior. The longer that staff delay data recording, the greater the probability that data are incorrect or inaccurate. By permitting data recording to be delayed for potentially several hours, the Facility had not ensured that data were accurate.
- For none of 12 reviewed PBSPs (0%) was data reliability consistently collected and reported. The majority of review progress notes stated that reliability had not been assessed.
- Nine of 12 reviewed PBSPs (75%) were reviewed by a BCBA. Only four of 12 PBSPs (33%), however, were provided that review on a monthly basis. For the majority of the PBSPs without monthly review, the BCBA did not conduct a review until approximately six weeks later. For example, several February 2013 progress notes were not reviewed by a BCBA until the second week in April. For three of 12 PBSPs (25%), there was no documentation of a review for at least one progress note.

Although improvement was noted in relation to data based modifications to PBSPs, there continued to be circumstances in which documentation did not reflect a review of available data.

- For Individual #44, the March 2013 progress note reflected that aggressive behavior had been above baseline for four of seven of the previous months (57%). In December 2012, the recommendation was made in the progress note

#	Provision	Assessment of Status	Compliance
		for the IDT to review the increase in aggression. No documentation provided by the Facility reflected that such a review was provided or that the PBSP was determined to be adequate. • For Individual #101, aggression remained above baseline for eight of the previous nine months. During the second through fourth months after the PBSP was implemented, episodes of aggression occurred at 400% of the baseline level. Episodes of aggression later decreased, but remained above baseline for all but one month. The information gleaned from progress notes suggested that much of the improvement in data based decisions involved PBSPs where behavior was stable at low rates and no reviews or revisions were warranted. In those circumstances when behavior did not respond to intervention strategies, however, documentation did not reflect that data were utilized in treatment decisions. Based upon the information obtained during the site visit, it was evident that data collection, presentation, and use at RGSC had improved. Documentation provided by the Facility, however, did not reflect that improvements were sufficiently comprehensive to meet substantial compliance with the Settlement Agreement.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	<u>Intellectual and Adaptive Assessment</u> Intellectual and adaptive 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 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 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. <u>Historical Perspective</u> At the time of the baseline visit, no individuals living at RGSC had been provided with a psychological evaluation. In February of 2011, the number of individuals with a psychological evaluation had increased to only 19%. During the February 2011, some evidence suggested that 99% of individuals had been provided psychological evaluations. Other documentation provided by the Facility, however, suggested a substantially lower number of completed psychological evaluations. Due to the discrepancy, it was not possible to determine compliance with the Settlement Agreement. During the August 2012 site visit, a sample of 10 psychological evaluation suggested RGSC had been unable to ensure psychological evaluations included current adaptive and intellectual assessments.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Current Site Visit During the current site visit, Psychological Assessment Reports for nine individuals were selected by the Facility. Based upon this sample, the Facility demonstrated substantial improvement in providing current assessments of intellectual ability and adaptive skills.	

	3/2010	8/2012	5/2013
A Psychological Assessment had been completed.	0%	100%	100%
The Psychological Assessment was less than one year old	0%	100%	100%
The Psychological Assessments contained findings from an intellectual test conducted within five years prior to the date of the Psychological Assessment.	0%	20%	100%
The Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.	0%	40%	100%

As the initial sample had reflected substantial compliance with the requirements of the Settlement Agreement in relation to the above elements, the Facility tracking data were used to review the Psychological Assessment report trends for all individuals. These tracking data revealed the following information.

- Two of 60 individuals (6%) had been provided no Psychological Assessment.
- Fifty-eight of 58 individuals (100%) had current intellectual and adaptive skill testing at the time of their Psychological Assessment.
- Twelve of 58 Psychological Assessment reports (21%) were more than a year old at the time of the site visit.

	5/2013	
	Initial Sample	Facility Population
A Psychological Assessment had been completed.	100%	94%
The Psychological Assessment was less than one year old	100%	79%

#	Provision	Assessment of Status	Compliance

The Psychological Assessments contained findings from an intellectual test conducted within five years prior to the date of the Psychological Assessment.	100%	100%
The Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.	100%	100%

Based upon this information, it was evident that that, despite the ratings for the nine Psychological Assessment reports included in the initial sample, RGSC had not acted to ensure that each individual was provided with adequate Psychological Assessments.

In addition to providing intellectual and adaptive skill 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. In none of the nine records (0%), the Facility had not provided detailed information of how the findings of the assessments could be integrated into the development of behavior interventions or skill acquisition plans. At most, the evaluation reports stated the general functioning level or personal strengths, but did not present the assessment information could be useful to the ISP process.

	3/2010	8/2012	5/2013
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 assessments current or otherwise would facilitate the understanding of the individual's strengths and needs.	0%	0%	0%

Based upon information obtained from the initial sample of nine records, RGSC had been unable to ensure the findings of intellectual and adaptive skill assessments were presented in a manner that facilitated the development of skill acquisition programs or contributed to the understanding of the person's strengths and needs.

#	Provision	Assessment of Status	Compliance
		Behavior Assessment Historical Perspective 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 vacant Psychology positions prior to the March 2012 site visit, though, sufficient samples were not available to judge how representative this improvement was. During the August 2012 site visit, it was suggested that a new SFA format and procedures reflected a substantial improvement over previous assessments. Current Site Visit At the time of the current site visit, a sample of nine Structural and Functional Assessments (SFAs) were selected by the Facility. The review suggested that the quality of the SFAs, while generally strong, may have dropped in all areas except in relation to the actual functional assessments procedures and tools.	

	3/2010	8/2012	5/2013
Assessment or review of biological, physical, and medical status	0%	100%	89%
Review of personal history	0%	100%	89%
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	0%	0%	89%
The process or tool utilizes both direct and indirect measures	0%	0%	89%
Identification of setting events and motivating operations relevant to the undesired behavior	0%	100%	89%
Identification of antecedents relevant to the undesired behavior	0%	100%	89%
Identification of consequences relevant to the undesired behavior	0%	100%	89%
Identification of functions relevant to the undesired behavior	0%	100%	89%
Summary statement identifying the variable or variables maintaining the target behavior	0%	100%	89%
Identification of functionally equivalent replacement behaviors	0%	100%	89%

#	Provision	Assessment of Status	Compliance

relevant to the undesired behavior			
Identification of preferences and reinforcers	0%	100%	89%

Although the data reflected a drop in SFA quality, that drop was due primarily to the failure of the Facility to provide a current SFA for one individual in the sample (Individual #97). The SFA provided for that individual was from March of 2011. Had a current SFA been provided that was similar to the remaining SFAs, it is possible that the Facility could have achieved a rating of 100% across the above domains.

Despite the relatively strong ratings presented above, there were additional areas in which documentation reflected substantial weaknesses in the SFA assessment process. These weaknesses involved the inability of the Facility to integrate the assessment of mental illness with the assessment of operant behavior.

	3/2010	8/2012	5/2013
Screening for psychopathology, emotional, and behavioral issues	0%	100%	0%
Differentiation between learned and biologically based behaviors.	0%	0%	0%
Identification of behavioral indices of psychopathology	0%	5%	11%
Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities	0%	0%	0%

It was noted that the psychiatrist frequently provided extensive assessment of psychopathology in individuals prescribed psychotropic medication. The resulting assessment reports included objective and subjective assessments, as well as differential diagnosis. All of the reviewed SFAs included some discussion of potential symptoms of mental illness and the pharmacologic treatment of those symptoms. Although these discussions often reflected the general findings of the psychiatrist's reports, no formal assessments or target symptom identification procedures were included. Furthermore, information was presented for only one of nine individuals (11%) to suggest that a formal behavioral assessment had been used to identify whether some mental illness symptoms were due in part to environmental conditions or could be treated through behavioral procedures. Due to the limitations noted, the ability of the reviewed SFAs to facilitate successful and relevant PBSPs was substantially limited.

Overall, information obtained from observations and documentation during the site visit

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>reflected a mixture of progress and continued weaknesses. In reference to 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.</td><td></td></tr>
<tr><td>K6</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.</td><td>Based upon the information presented in K5, documentation in the record continued to reflect that psychological assessments were not based upon complete clinical and behavioral data.</td><td>Noncompliance</td></tr>
<tr><td>K7</td><td>Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.</td><td>Based upon tracking data provided by the Facility, two individuals had been admitted to RGSC since the previous site visit. Records reflected that neither of these individuals (0%) had been provided a Psychological Assessment within 30 days of admission. Furthermore, tracking data reflected that neither individual (0%) had been provided a Psychological Assessment since their admission.

Documentation obtained during the current site visit also reflected that psychological evaluations had been completed at least annually for 46 of 60 individuals (77%).

<table><tr><td></td><td>3/2010</td><td>8/2012</td><td>5/2013</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>100%</td><td>77%</td></tr><tr><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>89%</td><td>100%</td><td>0%</td></tr></table>
Although previous efforts to provide the necessary intellectual and adaptive skill assessments, as well as regular Psychological Evaluation reports, were productive, there has been some decline in these efforts.</td><td>Noncompliance</td></tr>
<tr><td>K8</td><td>By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services.</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>
</table>

#	Provision	Assessment of Status	Compliance
	Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	Although not developed or supported by the Psychology staff, 10 SAPs utilizing sensory integration had been implemented at the Facility. These SAPs were presented as a means to improve individual behavior by organizing the mind, brain and body. Most often, the procedures used in these SAPs were brushing of the individual's extremities or the use of compression clothing or devices. Even though the SAPs were neither developed nor supported by the Psychology staff, the Occupational/Physical Therapy Evaluations and interviews with OT/PT staff reflected that the intent of the SAPs was at least in part to address behavioral challenges. These Occupational/Physical Therapy Evaluations, as well as the SAPs, were submitted to and approved by the IDT. The use of sensory integration procedures without support from individualized behavioral assessment is not supported in the current peer-reviewed research. Although assessments had been provided by SLPs and the OT/PT, these assessments did not incorporate behavioral assessment procedures and did not provide support for the use of individualized sensory integration. The ISPs for the individuals involved in the sensory-integration procedures did not reflect consideration of these SAPs or the specific procedures that were included. In addition to the lack of empirical support or pertinent individualized assessments, the sensory-integration SAPs did not include a means of objectively tracking any benefits from the programs. The author of the SAPs acknowledged the lack of objective data, but suggested that the broad benefits of sensory-integration were often difficult to define or capture through traditional data collection methods. Without research to support sensory-integration practices, individualized assessments to substantiate the need for sensory-integration with any individual living at RGSC, or a system for collecting data and monitoring treatment outcomes from the sensory-integration SAPs, there was little to suggest that benefit from the SAPs should have been anticipated. Furthermore, the decision to allow these SAPs to be implemented as developed reflected a considerable deviation from evidence-based practices. Although it is common for SSLCs to emphasize counseling services under Provision K.8, a variety of other intervention modalities can also be included. A Facility may already have in place formal and informal efforts to shape behavior that could be considered non-PBSP behavior interventions. For example, as part of the review for Section S, five dental rehearsal programs were reviewed. The Facility had not identified the dental rehearsal programs as non-PBSP interventions. As the focus of the programs was as much upon challenging behavior as skill acquisition, those programs could be considered non-PBSP interventions. Although the Facility did not identify these programs as involving	

#	Provision	Assessment of Status	Compliance
		psychological services, the programs reflected a positive and innovative approach to addressing undesired behaviors associated with dental treatment. Involvement of psychology staff could lead to implementing strategies that might be effective at addressing challenging behaviors. The available documentation did reflect, however, that the components of effective treatment and of monitoring efficacy could be developed if the Facility chose to do so.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	Informed consent requires that the consenter be provided with sufficient information about the proposed intervention to formulate a decision about whether or not to grant consent. In most situations, the consenter must be provided with the following information. • Implications of going without treatment and of treatment being postponed for different periods • The range of accessible diagnostic or treatment options • The benefits each option offers • The possibilities of diagnostic false results or treatment failures • The risks and discomforts of diagnostic or treatment options even when successful • Short-term injuries that diagnostic or treatment failures may cause • Long-term effects of diagnostic or treatment options, favorable and unfavorable, separating probabilities from possibilities It is the responsibility of the Facility to conduct the assessments essential for informed consent. 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. <u>Historical Perspective</u> 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 visit included consents that had expired and a lack of consents in the individuals' records. During the August 2012 site visit, consent forms were in 80% of records. These consent forms, however, did not provide specific information as to for what procedures consent was sought. <u>Current Site Visit</u> Of the seven individuals included in the current sample, the submitted records for six individuals included a signed consent form. Each of these "consent forms", however, included only generic statements indicating that neither psychiatric nor behavior	Noncompliance

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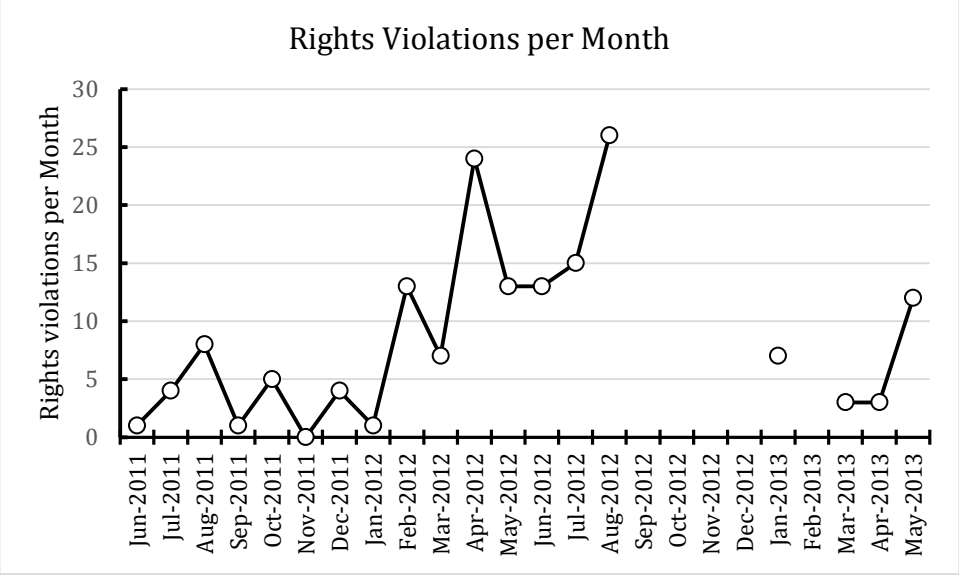
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>services represented an exact science and that no outcome could be guaranteed. There was no indication on the form as to what the representative was consenting. Based upon the provided information, although consents forms were in 86% 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>8/2012</td><td>5/2013</td></tr>
<tr><td>Necessary consents and approvals are obtained for each PBSP and safety plan prior to implementation.</td><td>78%</td><td>0%</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 rights violations 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 August 2012 site visit, rights violations had demonstrated an increase of more than 400% to 98 violations during the previous six months. As identified during the March 2012 site visit, the majority of violations identified in August 2012 reflected a failure by QDDPs and/or Human Rights Committee members to complete and submit the necessary forms and documentation.

During the current site visit, a request was submitted for documentation of all Human Rights Committee associated rights violations. The Facility was able to provide documentation for only January, March, April and May of 2013. Although this documentation suggested that the frequency of rights violations at RGSC had decreased, it was not possible to reach any conclusions due to concerns about the availability of documentation.</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		 Based upon information relating to consents and Human Rights Committee-related rights violations, it was evident that RGSC continued to experience difficulty in ensuring adequate protections for the individuals living at the Facility. <u>Behavior Interventions</u> <u>Historical Perspective</u> At the time of the August 2012 site visit, a new procedure and format for SFAs had been recently implemented. Only a limited number of PBSP were available for review. <u>Current Site Visit</u> At the time of the current site visit, the Facility selected nine individuals for inclusion in the sample of PBSPs. For one individual in the sample, Individual #97, no PBSP was submitted. As the sample was selected by the Facility, it was decided not to include the individual in the review for Provision K.9. | | 3/2010 | 8/2012 | 5/2013 | | --- | --- | --- | --- | | Rationale for selection of the proposed intervention | 0% | 100% | 100% | | History of prior intervention strategies and outcomes | 0% | 100% | 63% |	

#	Provision	Assessment of Status				Compliance
		Consideration of medical, psychiatric and healthcare issues	0%	100%	100%	
		Operational definitions of target behaviors	0%	100%	100%	
		Operational definitions of replacement behaviors	0%	100%	100%	
		Description of potential function(s) of behavior	0%	100%	100%	
		Use of positive reinforcement sufficient for strengthening desired behavior	0%	67%	63%	
		Strategies addressing setting event and motivating operation issues	0%	100%	88%	
		Strategies addressing antecedent issues	0%	100%	88%	
		Strategies that include the teaching of desired replacement behaviors	0%	100%	75%	
		Strategies to weaken undesired behavior	0%	100%	100%	
		Description of data collection procedures	0%	0%	13%	
		Baseline or comparison data	0%	83%	100%	
		Treatment expectations and timeframes written in objective, observable, and measureable terms	0%	100%	100%	
		Clear, simple, precise interventions for responding to the behavior when it occurs	0%	100%	75%	
		Plan, or considerations, to reduce intensity of intervention, if applicable	0%	100%	100%	
		Signature of individual responsible for developing the PBSP	0%	100%	88%	
		Based upon the information obtained from the sample, RGSC had demonstrated progress across most elements related to PBSP content in comparison with the original baseline visit. In comparison with the March 2012 site visit, ratings generally similar but were lower in some areas.. Because of the sample issues, it was difficult to draw conclusions regarding the quality of the PBSPs in terms of compliance. There were however areas of relative weakness. <u>Sufficient positive reinforcement</u> In order for desired behavior to be strengthened, the desired behavior must be followed by the presentation of a stimulus with reinforcing properties. In many circumstances, if the reinforcer is not powerful, the desired behavior will require more time to strengthen. It is therefore important that a powerful reinforcer				

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<tr><td></td><td></td><td>is identified and that the reinforcer is delivered in a manner that maximizes the reinforcement potential.

In four of the nine PBSPs (44%), it was not clear that a powerful reinforcer had been identified, or that the procedures for delivering the reinforcer were correct. For example, in some cases it was not evident that the reinforcer/preference assessment was sufficiently rigorous to identify the best reinforcer. There were also circumstances in which the PBSP instructions lacked specificity in describing how or when to deliver a reinforcer. As a result, it was not evident that a sufficient reinforcer was being delivered.

<u>Description of data collection procedures</u> Only one of 12 reviewed PBSPs (8%) reflected adequate data collection for target behaviors. In the majority of PBSPs, data collection instructions stated that data should be collected as soon as possible and at least by the end of the shift. To ensure that data are valid and reliable, it is essential that data be recorded as near in time as possible to the display of the behavior. The longer that staff delay data recording, the greater the probability that data are incorrect or inaccurate. By permitting data recording to be delayed for potentially several hours, the Facility had not ensured that data were accurate.

Due to the lack of documentation for one individual, weaknesses noted in three specific elements relating to PBSPs, and concerns about consents, it was not possible to determine that Provision K.9 was in compliance with the Settlement Agreement. It was evident, however, that RGSC had continued to progress toward compliance.</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>A sample of data graphs and progress notes was selected for 12 individuals. Based upon this sample, it was apparent that RGSC had achieved substantial progress in relation to the development of data graphs. In all but one area, data graphs were consistently in full compliance with expectations.

<table>
<tr><td>Graph Element</td><td>3/2010</td><td>8/2012</td><td>5/2013</td></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>0%</td><td>67%</td><td>100%</td></tr>
<tr><td>Horizontal axis and label</td><td>0%</td><td>67%</td><td>100%</td></tr>
<tr><td>Vertical axis and label</td><td>0%</td><td>67%</td><td>100%</td></tr>
<tr><td>Condition change lines</td><td>0%</td><td>67%</td><td>100%</td></tr>
<tr><td>Condition labels</td><td>0%</td><td>67%</td><td>100%</td></tr>
<tr><td>Data points and path</td><td>0%</td><td>67%</td><td>100%</td></tr>
<tr><td>IOA and data integrity</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Demarcation of changes in medication, health status or other events</td><td>0%</td><td>67%</td><td>100%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>In 12 out of 12 records, at least a substantial number of progress notes reflected that IOA had not been assessed. This lack of consistent reliability measures reflected that the Facility had made only slight progress since the baseline site visit concerning the quality of data being collected. As reliability data were not consistently collected, data graphs did not consistently include measures of reliability.

<table><tr><td></td><td>Baseline</td><td>8/2012</td><td>5/2013</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>
Other than the issues related to IOA and data integrity, the 12 sets of data graphs and progress notes were very thorough, included abundant treatment information, and reflected sophisticated graphing strategies.</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>The Facility reported during the current site visit that Microsoft Word was used to obtain readability statistics on direct service staff instructions for all PBSPs. The Facility tracking spreadsheet for PBSP reviews reflected that readability measures had been completed for 27 PBSPs since August 1, 2012. The average readability score for these 27 PBSPs was grade 8.1, with a minimum of grade 6.0 and a maximum of grade 10.0. This score was within the typically acceptable range of grade six to grade eight.</td><td>Substantial Compliance</td></tr>
<tr><td>K12</td><td>Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.</td><td>Documentation provided at the time of the current site visit reflected that a variety of training activities were conducted. A summary of scheduled trainings and dates was provided. The summary of scheduled trainings did not include measures of staff performance as an outcome of the training. A tracking spreadsheet for competency-based training was also provided by the Facility. Although this spreadsheet did present outcomes from training, it was evident that not all staff had been provided with training. In addition, there was no indication of the mechanism or rationale for selecting which PBSPs would be taught or which staff would be selected to participate.

Due to the limitations in the provided documentation, the following weaknesses were evident.
There was no indication that the Facility had implemented a comprehensive system of integrity checks to assess staff competence in reference to PBSPs and to provide competency-based retraining as needed.
The Facility did not present documentation that certain PBSPs had been identified as requiring CBT for all staff working with a particular individual.
The Facility did not present a measure or system for assessing the competence</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		of staff in relation to challenging behaviors that occur infrequently.	
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 62 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 30 individuals residing at the facility. 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. To accomplish this it will be necessary to 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)
2. The Facility is encouraged to develop and implement a 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 thorough discussion of the findings from the psychiatric assessment reports. In addition, there should be 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. Furthermore, 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 skill assessments, and ensure that test findings are incorporated into the ISP process. (Provision K5)
5. At the time of the site visit, the Facility had begun to identify other services that could benefit individuals experiencing challenging behavior or mental illness. In some circumstances (i.e. dental rehearsal), these programs did not include all necessary components of an evidence-based approach to treatment. In other cases (i.e. sensory integration), the Facility could not provide evidence that the service reflected accepted practices. It is recommended that RGSC develop a system to ensure that all 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. Develop and implement a system to ensure that rights violations, especially those due to failure to submit paperwork in a timely manner, are prevented. (Provision K9)
7. Develop and implement a system that ensures that PBSPs include all necessary elements prior to those PBSPs being implemented. (Provisions K3 and K9)

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-Assessment (4/29/2013) 2. RGSC Action Plan (4/25/2013) 3. Presentation Book, May 2013 4. DADS Policy: Medical Provider External/Internal Audits, revised July 6, 2012 – no number 5. Policy: Rio Grande State Center, Standard Operating Procedure EC403-02, Patient/Individual Immunization Program, revised October, 2011 6. Standard Operative Procedure, ICF-IID 400-17: Consultation Request Process, dated 1/30/2013 7. Certificate of primary care physicians CMEs obtained during the past six months for physicians 8. Copies of primary care physicians' Texas medical licenses 9. Copy of primary care physicians' CPR certificates 10. Blank copy of the Clinical Worksheet 11. List of individual-to-physician ratios 12. Schedule of all external medical consultations that were scheduled during the reporting period 13. List of all individuals with known diagnosis of malignancy 14. List of all individuals with diagnosis of cerebral palsy 15. List of all individuals who sustained a fracture during the reporting period 16. List of all individuals who had a diagnosis of seizure disorder 17. List of all individuals who experienced status epilepticus during the past six months 18. List of all individuals who developed pneumonia during the reporting period 19. List of hospitalizations that occurred during the reporting period 20. List of all individuals who were diagnosed with osteoporosis 21. Most recent ISPs for Individuals for Individual #150, #72, #4, #85, #93, #143, #126, #29, #19, #21, and #5 22. Internal medical audit materials for audits completed during the reporting period 23. External medical audit materials for audits completed during the reporting period 24. Copy of immunization records for first ten individuals on the name key 25. Morning medical rounds Meeting Minutes for March, April and May, 2013 **People Interviewed:** 1. Dr. David Moron, MD (clinical director) 2. Dr. Brian O'Donnell, MD **Meeting Attended/Observations:** 1. ISP meeting for Individual #134 2. Observations at all living areas 3. Morning Medical Meeting 5/16/2013
	Facility Self-Assessment: The Monitoring Team was pleased to see that the Facility enhanced its self-assessment by including the collection of data. With the exception of pneumonia, the self-assessment for Provision L.1 did not adequately assess the

	Facility's ability to manage many common and serious medical conditions. For example, there was no self-assessment for the management of cerebral palsy, constipation, diabetes, or musculoskeletal issues. Also, the self-assessment did not assess the quality or clinical relevance of issues assessed. For example, the Facility stated that it examined its risk rating database to ensure all individuals have a current risk rating for each category; however, the Facility did not assess completeness and clinical relevance for the category of "other" on the risk rating assessments. Also, the self-assessment for Provision L.1 addressed only the risk rating process, and no other clinical function. The self-assessment should assess all components of a comprehensive action plan that addresses compliance issues for the SA. The Monitoring Team disagreed with the Facility's self-assessment of pneumonia because it is difficult to conclude if pneumonia was aspiration or acquired pneumonia. Also, the Monitoring Team's review of four cases of pneumonia concluded that the cause was most likely secondary to aspiration. For Provision L.2, when assessing the medical audit process, the Facility focused on specific compliance rating for each physician but did not assess the comprehensiveness of the medical audit process. The Facility should assess the quality, and quantity of medical management elements. The Facility should assess if the actual clinical practice was within the scope of generally acceptable clinical practice. For Provision L.3, the Facility did not assess development and implementation of a medical quality assurance process. The Facility should assess its development of specific medical quality indicators, and how the Facility utilizes outcome studies to enhance the provision of medical services. For L.4, the self-assessment reported that the Facility was reviewing a newly developed DADS medical care policy; however, because it was not implemented, the Facility did not assess its effectiveness. Also, the self-assessment should assess if there are functional, and well implanted policies, procedures, and/or guidelines for all medical related systems at the Facility. The Facility also provided an action plan for progressing toward compliance. The action plan did not offer a comprehensive plan to address compliance issues for the SA. For example, the action steps listed for L.1, focused only on CME certificates; creating an database for tracking mammograms, colonoscopy, ER visits, and neurology consultations, and two other components. The action-plan did not address general clinical operations, or other relevant components of the SA.
	Summary of Monitor's Assessment: The Monitoring Team noted significant improvement in many areas of medical services. Individuals were evaluated by the physician more timely than noted at prior Monitoring Team reviews, and the documentation of follow-up was more comprehensive; diagnoses were updated promptly. The Facility was able to retrieve updated diagnoses efficiently, by means of an electronic database. Follow-up on fractures, malignancy, and many other clinical conditions were noted to be greatly improved. The IPNs and annual medical assessments were documented by the physician timely and comprehensively. The Facility maintained a more comprehensive medical consultation scheduling process, and better ensured that individuals were followed-up regularly by necessary external medical consultants. The medical

	examination room and equipment were determined to be excellent, and enabled the physician to complete comprehensive examinations. Substantial compliance will, however, require that the Facility improve on medical services by ensuring more robust participation by primary care specialists in the IDT process; improve on follow-up more regularly on chronic care issues; enhance continuity of care for individuals hospitalized; and provide close follow-up and documentation through full resolution of all clinically relevant acute care conditions. The Facility must also develop and implement a medical quality assurance process, and ensure that there are policies, procedures, and/or guidelines for all system related clinical processes. The following are specific issues related to each Provision: Provision L1: The Monitoring Team concurred with the Facility's self-assessment of noncompliance with Provision L.1. Substantial compliance will, however, require that the Facility improve on medical services by ensuring more robust participation by primary care specialists in the IDT process; improve on follow-up more regularly on chronic care issues, such as cerebral palsy; enhance continuity of care for individuals hospitalized; and close follow-up and documentation through full resolution of all clinically relevant acute care conditions. Provision L2: The Monitoring Team determined non-compliance for Provision L.2. Although the Facility conducts regularly scheduled external medical audits and action plans were developed, implemented, and completed, as necessary, the Facility must enhance the medical audit process by ensuring that medical management elements are developed for the most common, and most serious medical conditions that occur in people with intellectual disability; that a sound sample of records are reviewed for each audit; and that the results of the audits are used by the Facility to help enhance and monitor physician performance. Provision L3: The Monitoring Team agrees with the Facility's self-assessment of noncompliance with Provision L3. Substantial compliance will require the medical audit process to include additional medical management elements, and that medical management elements be developed for the most common and serious medical conditions that occur in individuals with intellectual disabilities. Also, the Facility must develop and implement a clinically relevant medical quality assurance process to routinely assess system issues and clinical outcomes of medical care. The Facility should ensure that quality outcome measures are developed for the most common and serious medical conditions that occur in individuals with intellectual disabilities, and for adverse outcomes to medical care. Provision L4: The Monitoring Team determined that the Facility was not in compliance with Provision L.4. Substantial compliance will require the Facility to have developed and implemented clinical policies, procedures, and/or guidelines for clinical systems at the Facility.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two	To assess compliance of Provision L1, the Monitoring Team observed individuals at their living areas, attended morning medical rounds, discussed clinical issues and concerns with the medical staff, reviewed clinical records, and observed individuals at their home.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Specific issues addressed during this review period included seizure disorder, pneumonia, fractures, acute medical conditions, osteoporosis, follow-up to hospitalizations, degenerative spine disease, malignancy, and do not resuscitate orders (DNR). In addition, medical administration was assessed, including a review of the Interdisciplinary Team (IDT) participation by medical practitioners, medical staff credentials and training, and the Facility's ability to manage clinical database elements and external consultation scheduling. <u>Medical Administration</u> The Facility maintains one full time board certified primary care specialist (PCP) who provided primary care medical services to the Individuals at the Facility. At the time of this review the ratio of individuals served by the physician was 63 to 1, which is a favorable ratio. The Facility had excellent cross coverage service for after hours, and other occasions when the PCP was off duty. All physicians who provided direct care were currently licensed, had current CPR certification, and attended continuing medical education venues. The Monitoring Team was impressed by the Facility's ability to manage clinical database elements. For example, the Monitoring Team requested a comprehensive list of individuals who had specific diagnoses, including diabetes, arthritis, pneumonia, cerebral palsy, among other diagnoses. The Facility was able to provide an updated list within a reasonable period of time (1.5 hours) that was accurate and current when cross referenced to specific diagnosis listed for Individuals in the clinical record, It was noted that the Facility had a process to update all medical diagnoses at the time of service. For example, when the PCP evaluates an Individual, and adds or deletes a diagnosis, a form is completed at the time of service, and the electronic database is updated immediately. The Facility also maintained a process to closely monitor its external consultation schedule and was able to report the type of consultation, date scheduled, necessary follow-up appointments, and if the appointment was attended by the Individual and, if not, the reason why the appointment was not attended. The Monitoring Team was impressed by the quality of the medical examination room. The room provided necessary privacy, was well lit, had updated and functioning medical equipment, and provided an adequate examination table. Summary: The Monitoring Team determined that the Facility maintained an excellent medical staff, was able to manage database elements, and provided adequate examination room space and equipment. The Facility should take notice of a Federal requirement for implementation of a certified electronic health care record by January 1, 2015.	

#	Provision	Assessment of Status	Compliance
		External Medical Consultations To assess availability of external medical consultants, and related missed appointments, the Monitoring Team discussed the issue with the clinical director, and reviewed the Facility's scheduling of external medical appointments for the past six month period. At the time of this review, the Facility did not have a process for regularly analyzing missed appointment data, and the schedule provided included not only medical consultation appointments, but also dental and imaging appointments. Review of the schedule indicated that the current format would make it difficult to track specific date elements and perform a comprehensive trends analysis of medical appointments. This is, however, a good beginning; the Facility should consider how to revise this so that it can be used more easily to provide information for decision-making. The clinical director indicated that there were no limiting factors with regards to obtaining timely external medical consultations, when clinically needed. Review of the external medical consultation schedule indicated that the Facility had scheduled follow-up with various medical consultants, including urology, pulmonology, ophthalmology, neurology, podiatry, nephrology, general and orthopedic surgery, oncology, gastroenterology, ENT, gynecology, and cardiology. Review of the external medical consult schedule for January, 2013 indicated that a total of 70 external medical consultations were scheduled, and 62 out of 70 (89%) were attended as scheduled. Of the eight appointments missed, there was documentation for the reason why the appointment was missed in eight out of eight case (100%); and an action plan for follow-up was documented in 8 (100%), out of the eight missed appointments. Summary: The Monitoring Team noted that the Facility utilizes a variety of external medical consultants, and maintained a spreadsheet documenting appointments dates, when an appointment was missed, and specific follow-up plans. The Monitoring Team recommends that the Facility develop and implement a process to regularly review and analyze system issues related to missed appointments, and develop action plans to correct underlying system issues, when necessary. Management of Malignancies The Facility reported one Individual who had a diagnosis of malignancy. Individual #150 was diagnosed with gastric cancer: • Initial triage by the physician was timely, and clinically appropriate. • Appropriate referrals were made to clinically appropriate medical consultants. • Integrated progress notes (IPNs) documented comprehensive follow-up to	

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		cancer diagnosis. • The individual support plans (ISP), and addendums to the ISP, dated 2/12/2013; 1/25/2013; 1/15/2012; 12/20/2012; 11/30/2012; 11/29/2012; 11/26/2012; 10/24/2012; and 10/17/2017, documented the Individual's diagnosis of gastric cancer, related treatments, clinical issues, and necessary supports. Summary: It was evident by document review that this Facility provided exceptional medical care for the management of malignancy. The PCP consistently followed the Individual for the diagnosis of malignancy, related treatments, and for other acute care issues that occurred during the past six months. The Facility ensured that interdisciplinary team meetings took place to address the Individual's needs. <u>Management of Cerebral Palsy</u> To assess the Facility's ability to manage cerebral palsy (CP) the Monitoring Team reviewed the most recent annual medical assessment, available physician IPNs, PT/OT assessments, the most recent ISP, and risk rating assessments, associated medical consultations, and current medication list, for all six individuals (Individuals #85, #118, #91, #51, #143, and #19) who were reported as having a diagnosis of CP. Of the six cases reported: • Two out of six (33%) documented an active diagnosis for CP on the annual medical assessment. • Zero out of six (0%) annual medical assessments had a clinically appropriate medical plan listed on the annual medical summary. • Zero out of six (0%) ISP documented CP as a clinical issue, along with documentation on how this condition affects the Individual, its prognosis, and all necessary supports and treatments for the condition. • Zero out of six (0%) were regularly followed by medical consultants who have expertise in the management of CP • Two out of six (33%) PT/OT assessment documented a clinically appropriate assessment of the individuals CP. • Zero out of six (0%) were periodically followed throughout the monitoring period by the PT/OT for CP. Summary: The Monitoring Team determined that the Facility did not adequately manage cerebral palsy. For example, several cases had a diagnosis of history of cerebral palsy. CP is a dynamic and lifelong condition that requires on-going medical assessment, and specific treatments to address clinical manifestation of CP. PT/OT services did not assertively	

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		evaluate CP as diagnosis, nor provide necessary treatments, under the periodic assessments by the PT/OT. The Facility must enhance its overall management of all Individuals with neuromotor conditions, such as CP. Medical Management of Fractures To assess medical management of fractures the Monitoring Team reviewed clinical information on the two individuals reported to have sustained a fracture during the reporting period: Because the of difficulties with ambulation, and a history of multiple fractures, Individual #72 had an x-ray of the hip on 3/10/2013 because of a suspicion of having a fractured hip; however, it was determined that there was no definitive fracture. Review of the annual medical assessment demonstrated a comprehensive review of all known orthopedic condition, review of fracture risk, and development of a clinically appropriate action plan for the orthopedic conditions. The medical IPNs demonstrated follow-up to the suspected fracture and hip pain. Addendum to the ISPs demonstrated excellent review of the individual's risk for fracture, and need for enhanced support. Individual #27 sustained a nasal fracture, and was triaged to the emergency department, was evaluated by the Facility's PCP, underwent necessary x-rays, and was followed closely by the PCP following the initial assessment. Addendum to the ISPs noted necessary follow-up on the fracture, and related incident. Summary: The Monitoring Team determined that the Facility provides very good medical assessments, treatments, and follow-up to fractures, and suspected fractures. Because of the nature of the two reported fractures, the Monitoring Team could not assess the primary care physician's (PCP's) involvement in helping to determine the etiology of fracture, and will continue to assess for this at future Monitoring Team reviews. Medical Management of Seizure Disorder The Monitoring Team requested the clinical records of the first seven individuals on a list of all individuals reported to have seizure disorder, and the three individuals reported to have had status epilepticus. The clinical records for nine of the ten cases requested were provided (Individuals #72, #118, #51, #15, #82, #12, #29, #60, and #145). The following clinical reports were reviewed: EEG, imaging studies of the brain, neurology consult reports, medication list, seizure reports, most recent ISP documenting seizure disorder, annual medical summary, and PCP IPNs documenting follow-up to seizures. • Eight out of nine annual medical assessments indicated a diagnosis of seizure disorder (89%), and one out of nine (11%) indicated an accurate diagnosis, specific for the type of seizure disorder.	

#	Provision	Assessment of Status	Compliance
		• Seven out of nine cases (78%) were seen regularly by a neurologist. • Seven out of nine (78%) had EEG completed within the past three years. • Seven out of nine (78%) had neuroimaging within the past five years. • Zero out of nine (0%) included a physician IPN documenting follow-up after a reported seizure. • Seven out of nine (78%) included a seizure record. • Four out of nine (44%) ISPs documented seizure disorder, and how seizure disorder impacted the individuals life and requires support services. Summary: The Monitoring Team noted significant improvement on documentation of seizure disorder, ensuring that appropriate diagnostics were available for review, and follow-up with the neurologist. The Facility must ensure that the physician provides regular follow-up and assessment of Individuals who experienced a seizure. Also, the Facility must improve on reporting and documenting review of seizure disorder within the context of the ISP, as in the case of the annual ISP for Individual #60. The ISP should document how the seizure disorder impacts the individual's life, prognosis, and all necessary supports and services. The physician should ensure that the classification of seizure disorder is well documented as a diagnosis, such as in the case of #118. The Monitoring team did not conduct a review of the use of older anticonvulsants, and anticonvulsant polypharmacy, but will review in the future. <u>Immunization and Vaccination Process</u> To assess the Facility's ability to provide vaccination, determine immunization status, and maintain immunization and vaccination records, the Monitoring Team reviewed the immunization records of ten individuals, observed the electronic database that tracks and trends immunization and vaccination status, and obtained a copy of the Facility's policy for immunization and vaccination - Policy: Rio Grande State Center, Standard Operating Procedure EC403-02, Patient/Individual Immunization Program, revised October, 2011 This policy did not clearly delineate the Facility's process to determine immunization status, or the process of providing and document scheduled vaccinations, in accordance with CDC guidelines. Although the Policy indicated that it was revised in October, 2011 the attached CDC references were dated 2013, and were merely the CDCs vaccination schedule. Review of immunization records indicated: • Seven out of ten cases (70%) indicated either proof of prior immunization, or evidence of immunization for measles, mumps, and rubella (MMR).	

#	Provision	Assessment of Status	Compliance
		• Ten out of ten cases (100%) indicated current influenza vaccination. • Ten out of ten cases (100%) indicated either proof of varicella zoster immunization, or vaccination. • Nine out of ten cases (90%) indicated current vaccination for either tetanus and diphtheria (Td), and when clinically appropriate pertussis (Tdap) - (Individual #27 was last vaccinated for Td on 7/2002 and is due to Tdap). • Ten out of ten cases (100%) demonstrated immunity, or had immunization records for hepatitis B. The Monitoring Team was made aware of the Facility's immunization database, which electronically tracks and trends immunization and vaccination status. The Monitoring Team noted its efficiency and effectiveness in helping to ensure that individual's immunization and vaccination status was documented, in accordance with the CDC guidelines, for scheduled vaccinations. In addition, the Facility provided appropriate historic documentation for MMR status, per CDC documentation guidelines. Summary: The Facility maintained a robust immunization and vaccination process. The Monitoring Team recommends the Facility develop either a policy or procedure that delineates this process. <u>Medical Management of Pneumonia</u> For the four individuals who were reported to have had pneumonia during the reporting period (Individuals #72, #19, #134, and #158), the Monitoring Team assessed physician IPNs, x-rays, ISPs, risk rating assessments, swallowing studies, and specific consultations for treatment and follow-up to pneumonia: • Three out of four (75%) had an initial assessment documented by the physician, and the remaining one was initially assessed by hospital physicians. • Four out of four cases (100%) indicated a follow-up assessment by the physician, and two out of four (50%) indicated more than one follow-up, following the diagnosis of pneumonia. • Four out of four cases (100%) were noted to have had imaging studies to help determine resolution of pneumonia. • One out of four (25%) addendums to the ISPs documented the impact of pneumonia on the individual's lives, prognosis, and all necessary supports and services necessary to help prevent recurrent pneumonia. • Swallow studies were noted to have been completed following each case of pneumonia in four out of four cases (100%). Summary:	

#	Provision	Assessment of Status	Compliance
		The Monitoring Team noted improvement in the Facility's assessing of pneumonia by the physician, since the last review. The Monitoring Team recommends further enhancement specific to more frequent follow-up by the physician, and more detailed analysis, and recommendations for pneumonia through the ISP process. The ISP must include or reference strategies to help mitigate recurrence of pneumonia, and identify how recurrent pneumonia impacts the Individual's life. <u>Physician Follow-up to Acute Medical Conditions</u> To assess the Facility's ability to manage acute medical conditions, the Monitoring Team selected five Individuals, based on acuity of the condition, from a list of all acute medical issues that occurred during the reporting period. Individual #72 was triaged for pneumonia; Individual #40 was triaged for UTI and fever; Individual #60 was triaged for suspected fracture of the nose; Individual #118 was triaged for abdominal pain; and Individual #126 was triaged on two occasions for rectal bleeding. Specific documents included were physician IPNs through full resolution of the condition and related diagnostic and consultation reports: • Five out of five cases (100%) demonstrated a comprehensive initial evaluation that included a clinical impression and plan. • Five out of five cases (100%) were noted to have a follow-up progress note by the physician; however, only two out of five cases (40%) had more then one follow-up note, documenting full resolution. Individuals #126, and #72 demonstrated follow-up by the physician through full resolution of the condition. • Five out of five cases (100%) were noted to have appropriate diagnostics orders for the condition. • Five out of five cases (100%) were either triaged to the emergency department, or medical consultant, as required clinically. Summary: The Monitoring Team noted continued improvement with follow up on acute medical conditions. The Monitoring Team recommends that the Facility ensure that all acute medical conditions are seen, as clinically necessary, through full resolution of the condition. <u>Medical Management of Osteoporosis</u> From a list of all individuals with osteoporosis, the Monitoring Team requested clinical records for the first ten (Individuals #72, #4, #85, #93, #143, #126, #29, #19, #21, and #5). Documents reviewed included the annual medical assessment, most recent two bone density assessments, laboratory studies, current medication list, and clinical documentation to demonstrate that an underlying etiology for osteoporosis was	

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		evaluated: • Nine out of ten cases (90%) indicated a diagnosis of osteoporosis on the annual medical assessment. Individuals #72 did not indicate osteoporosis on the annual medical assessment. • Ten out of ten cases (100%) had documentation that calcium and vitamin D levels were evaluated within the past year. • Nine out of ten (90%) had evidence that a diagnostic was obtained to evaluate bone density. Individual #85 was determined to have challenging behaviors that would not enable a bone density study, in 2008. If clinically needed, there should be review documented in the medical plan or ISP indicating whether a bone density study could be conducted at this time. • The ISP documented the diagnosis of low bone density, how low bone density impacts the Individual's life, prognosis, and all necessary services and supports to manage osteoporosis in zero out of ten cases (0%). • Treatment doses of Vitamin D and calcium, or the clinical rationale why these were not provided, were noted in nine out of ten (90%) cases. • A bisphosphonate or other medical treatment was prescribed for seven out of ten cases (70%). There was no documented rationale why the remaining three individuals were not prescribed. • The annual medical assessment documented the diagnosis in all cases. • There was a medical plan documented on the annual medical assessment for osteoporosis in nine out of ten cases (90%). • Zero out of ten cases (0%) were reported by the Facility to have had completed an evaluation to help determine the underlying etiology of low bone density. Summary: The Monitoring Team noted that in no cases was there a completed assessment to help determine the underlying medical cause for low bone density. Also, the Monitoring Team is concerned that there was not documentation in the ISP or elsewhere of the prognosis, how the condition affects the individual's life, prognosis, and all necessary treatments, and supports were not adequately reported. <u>Hospital Follow-up</u> To assess the Facility's ability to ensure continuity of care for an acute hospitalization, the Monitoring Team requested the clinical documentation for the most recent ten hospital admissions, and the Monitoring Team was provided with the following nine samples: Individuals #77 (two admissions), #19, #97, #40, #79, #60, #4, and #94. Specific documentation reviewed were Facility hospital liaison notes; hospital related ISPs; hospital transfer note; hospital admission and discharge summaries; evidence of Facility's physician communication with hospital, and Facility physician pre-hospital and	

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		post-hospital IPNs. • There was evidence of a pre-hospital IPN by the physician, specific for the hospitalization, in one out of nine cases (11%). • There was evidence that the physician documented a post hospital discharge note in eight out of nine cases (89%). • A hospital transfer form was noted for eight out of nine cases (89%). • There was documentation of hospital liaison communication in three out of nine cases (33%); however, in one case, the liaison communication occurred only on one day, of a multiday admission (individual #77). • There was evidence that a specific post hospital ISP was developed in seven out of nine (78%). There was no post hospital ISP addendum noted for Individual #4, and only one ISP addendum for the two back-to-back hospital admissions for Individual #77. • A primary care physician participated at one out of nine (11%) post hospital IDT meetings. Summary. The Monitoring Team noted improvement with post hospital follow-up; however, the Facility must continue to enhance continuity of care. The post hospital discharge note by the physician did not summarize the hospitalization and important clinical issues. For example, there were four cases of dehydration that were diagnosed by the hospital (Individuals #4, #79, #40, and #19), but not mentioned in the post discharge follow note; also Individuals #97, and #19 were noted to have low anticonvulsant levels upon admission to the hospital, and this issue should have been well documented by the Facility's physician, and reported at the post hospital IDT meeting. Although ISPAs were occurring more regularly, they do not always include important clinical details. For example, Individual #97 was hospitalized for seizures, and his Dilantin level was noted to be low on admission, and the ISPA did not include this in the analysis of the hospitalization, and when developing a post hospital plan for the Individual. Of concern is that there was little evidence to support the involvement of a primary care physician in the development of the post hospital ISPA. <u>Physician representation in the ISP Process</u> To assess the physician's participation in the ISP process, the Monitoring Team attended the ISP meeting for Individual #134, and reviewed the annual ISP, and associated sign in sheets for the sample selection used to assess osteoporosis, for this report (Individuals #72, #4, #85, #93, #143, #126, #29, #19, #21, and #5) The Monitoring Team attended the ISP meeting for Individual #134 on 5/14/2013. A primary care physician was not present for the meeting; however, healthcare issues were	

#	Provision	Assessment of Status	Compliance
		represented by a nurse. The contract psychiatrist addressed psychiatric issues, and psychotropic medications. The Monitoring Team noted an excellent review of some medical care issues. For example, the issue of recurrent balinitis, and phimosis and the need for possible circumcision, and improved daily hygiene was well discussed with the Individual. The IDT also discussed the Individual's diabetes, and weight loss issues very well. Although the psychiatrist did inform the team about the important need to follow-up on a repeat sleep study for obstructive apnea, the IDT did not discuss potential reasons for the Individual's refusal of the CPAP device, or the possibility of developing behavioral approaches to better help the Individual adapt to the device. Two additional clinically relevant issues were not well represented, in the context of the ISPA meeting. The Individual had experienced clinically significant fluctuation with thyroid levels. Fluctuating thyroid levels can affect behavior, cardiac function, and metabolism, among other conditions; however, this issue was not well represented at the ISP. The Individual was noted to have a diagnosis of diverticulosis, and a GI consult recommended monitoring for this condition. The issue of diverticulosis was not addressed at the ISP meeting. The IDT reviewed choking and aspiration risk, and commented that the Individual had not aspirated, or choked recently; however, the most recent modified barium swallow test indicted that the Individual did experience silent aspiration, with thin liquids. Although there were no formal recommendations by the speech pathologist to adjust liquid consistency for silent aspiration, the IDT should have commented on this risk, and potential adverse outcome from chronic silent aspiration. Review of ten ISPAs (Individuals #72, #4, #85, #93, #143, #126, #29, #19, #21, and #5) indicated that the primary care physician participated at zero out of ten ISP meetings (0%). Summary: The Monitoring Team noted improvement on presenting health care issues at the ISPA meeting; however, the Facility did not address several important clinical issues, that could adversely affect the Individual's life, and a primary care physician did not participate at any of the ten ISPA meetings reviewed, and did not participate at the ISP meeting that the Monitoring Team attended. The Facility must enhance primary care representation in the ISP process. <u>Management of Chronic Medical Conditions</u>: Review of the clinical records of Individuals #72, #4, #85, #93, #143, #126, #29, #19, #21, and #5 indicated that the primary care physician did not regularly assess chronic medical conditions, outside of the annual medical assessment. During past Monitoring Team reviews, it was reported by the primary care physicians that they were developing	

#	Provision	Assessment of Status	Compliance
		a quarterly medical assessment process that would address chronic conditions; however, of the ten examples, zero out of ten (0%) demonstrated a quarterly medical assessment. Summary The Facility must develop and implement a process to ensure that clinically relevant chronic care issues are specifically addressed by the primary care physician. For example, an Individual with diabetes should be seen approximately every three months to fully address issues related to diabetes, and Individuals with moderate to severe degenerative joint disease should be evaluated periodically for clinical worsening. <u>Conclusion</u> The Monitoring Team noted significant improvement in many areas of medical services. Individuals were evaluated by the physician more timely, and more comprehensively; diagnoses were updated promptly; The Facility was able to retrieve updated diagnoses both timely and effectively, by means of an electronic database; follow-up on fractures, malignancy, and many other clinical conditions was noted to be greatly improved. The IPNs, and annual medical assessments were documented by the physician was timely and comprehensive. The Facility maintained a more comprehensive medical consultation scheduling process, and better ensured that individuals were followed-up regularly by necessary external medical consultants. The medical examination room and equipment were determined to be excellent, and enabled the physician to complete comprehensive examinations. Substantial compliance will, however, require that the Facility improve on medical services by ensuring more robust participation by primary care specialists in the IDT process; improve on follow-up more regularly on chronic care issues; enhance continuity of care for individuals hospitalized; and close follow-up and documentation through full resolution of all clinically relevant acute care conditions.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	To assess the Facility's development and implementation of a review system that consists of non-facility physician case review to facilitate the quality of medical care and clinical performance, the Monitoring Team reviewed the external medical audit reports and associated policies and procedures for the medical audit process (DADS Policy: Medical Provider External/Internal Audits, revised July 6, 2012 – no number). The Facility did not experience a death so a review of death summaries was not completed for this review period. <u>External Medical Audits.</u> The two primary care physicians who provide regular medical services to the Facility were assessed through the external medical audit process that was conducted on November 8, 2013. A five percent sample of records was examined for each physician for compliance with 30 requirements. The requirements were divided into essential and nonessential elements. In order to obtain an acceptable rating, essential items were	Noncompliance

#	Provision	Assessment of Status	Compliance
		required to be in place, in addition to receiving a score of 80% on nonessential elements. • For the full-time physician, three records were audited. For the part-time physician, one record was audited. This totaled four records, or 6% of total individuals in residence. • Two out of two (100%) physicians achieved a Facility determined passing score of 80% or more for non-essential elements. • Zero out of two (0%) physicians achieved a Facility determined passing score of 100% for essential elements. • Two out of two (100%) physicians achieved a Facility determined passing score of 80% or greater for medical elements • A total of 16 corrective action plans were developed at the time of this review, and 16 out of 16 (100%) were completed. Although requested, there was no documentation by the clinical director to explain how the results of the medical audits were used in the context of enhancing and monitoring physicians' clinical performance, or when a meeting between the clinical director and audited physicians occurred. These reviews focused on processes and did not provide measures of clinical outcomes. Furthermore, the Monitoring Team was concerned that this number of clinical records reviewed. Although a five percent sample may provide enough records for review in a larger facility, it does not provide an adequate sample in a facility serving this smaller number of individuals. The Monitoring Team recognizes that this sample fulfills State Office requirements. In addition to the general medical audits, external medical management audits were conducted for three conditions (urinary tract infections, seizures, and constipation); although this meets the requirements of the procedure established by DADS, it does not provide a complete picture of the quality of medical care provided. To move toward compliance with this provision, the Monitoring Team recommends additional conditions commonly found in this population must be included in the audits, at least on a rotating basis. Summary: The Monitoring Team noted that a medical audit by an external physician was completed when scheduled, and that action plans for missed elements were developed and completed as required. The Monitoring Team continues to be concerned with the low number of clinical records assessed during the audit process, that there was no information as to how the audit were specifically used to enhance and monitor physicians' clinical performance, and the limited number of medical management	

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		elements that have been developed for the medical audit process. <u>Mortality Review Process</u> The Monitoring Team does not have a report related to review of deaths, as there were no deaths among individuals at the Facility since the last compliance visit. Conclusion: The Facility conducts regularly scheduled external medical audits, to help assess the clinical performance of physicians. Action plans were developed, implemented, and completed. The Facility must enhance the medical audit process by ensuring that a medical management elements are developed for the most common, and most serious medical conditions that occur in people with intellectual disability; that a sound sample of records are reviewed for each audit; and that the results of the audits are used by the Facility to help enhance and monitor physician performance.	
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.	To assess the Facility's ability to develop and implement a process for medical quality assurance, that it collects clinical data, and conducts trends analysis of clinical outcomes, the Monitoring Team discussed the Facility's medical quality assurance process with the clinical director, and reviewed the most recent internal medical audits. <u>Internal Medical Audits</u> The most recent internal medical audit occurred on 2/25/2013. The two practicing primary care physicians were assessed by the internal medical audit process: • Two out of two (100%) physicians achieved a Facility determined passing score of 80% or greater for non-essential elements • Zero out of two (0%) physicians achieved a Facility determined passing score of 100% for essential elements • Two out of two (100%) physicians achieved a Facility determined passing score of 80% or greater for medical elements • Of the 21 corrective actions developed for the medical audits, 21 out of 21 were completed by the time of this review. The Monitoring Team noted that only three medical management elements were assessed (urinary track infection, constipation and seizure disorder). <u>Medical Quality Assurance Process</u> The clinical director informed the Monitoring Team that the Facility did not have a quality assurance process to assess clinical outcomes. The Facility provided a listing of additional elements to be tracked. Although the Facility had begun to track indicators for episodes of possible aspiration and constipation, and had added tracking of BMI, lipids, seizures, and A1c (related to diabetes), there was not yet a process to bring this	Noncompliance

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		information together into a medical QA process. Furthermore, as noted in Provision M5, although bowel tracking had been put in place to identify episodes of constipation, there had been no process to ensure reliability of the entries, and the system did not appear to be providing accurate information. It will be essential for processes to be in place to ensure that any quality assurance information is accurate. Conclusion: The Monitoring Team noted that internal medical audits were conducted as scheduled, and that all action plans developed for missed items where completed by the time of this review. The Monitoring Team is concerned that the audit process did not have the ability to assess additional medical management elements, and recommends that medical management elements be developed for the most common and serious medical conditions that occur in individuals with intellectual disabilities. Also, the Facility must develop and implement a clinically relevant medical quality assurance process to routinely assess system issues, and clinical outcomes of medical care. The Facility should ensure that quality outcome measures are developed for the most common and serious medical conditions that occur in individuals with intellectual disabilities, and adverse outcomes to medical care.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Monitoring Team requested all policies, procedures, and guidelines that were either developed or revised during the review period. The Monitoring Team was made aware that DADS central office was in the process of developing a new medical policy; however, at the time of this on-site review, it was not available hence, will be reviewed at subsequent Monitoring Team reviews. During the review period, the following was developed: <u>Policies</u> Standard Operating Procedure, ICF-IID 400-17: Consultation Request Process, dated 1/30/2013. This policy documents the Facility's new process to ensure medical consultations and diagnostics are obtained timely, and was noted to appear as an effective process to help facilitate consultations, and medical related diagnostics <u>Clinical Worksheet</u> A new worksheet was developed to help ensure that physicians collect, document, and assess all relevant clinical information when providing direct clinical care to Individuals. There were no associated guideline, policy or procedure. Conclusion: The Monitoring Team recommends that the Facility ensure that a policy, procedure, and/or guidelines are developed for all system issues related to clinical practice.	Noncompliance

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		Compliance will require the Facility to have developed and implemented clinical policies, procedures, and/or guidelines for all clinically relevant systems at the Facility.	

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

1. Develop and implement a process to regularly review and analyze system issues related to missed appointments, and develop action plans to correct underlying system issues, when necessary. (Provision L.1)
2. Enhance clinical management of neuromotor conditions, including cerebral palsy. (Provision L.1)
3. Enhance the representation of medical issues within the context of ISPs and ISPAs. All clinical issues must be well understood by the IDT, including all relevant clinical conditions, how the conditions affect the Individual's life, prognosis, and all necessary treatments, and services required to support the Individual. (Provision L.1)
4. The primary care physician must regularly follow-up on all acute medical conditions, and document follow-up through full resolution of that condition. (Provision L.1)
5. The primary care physician must regularly assess seizure frequency, and assess individuals following a seizure. (Provision L.1)
6. The primary care physician must enhance follow-up of pneumonias, and attempt to ensure that the underlying etiology of pneumonia is well represented at the IDT meeting. (Provision L.1)
7. All cases of low bone density should be assessed as to the underlying etiology. (Provision L.1)
8. Enhance processes for continuity of care for all hospital admissions. (Provision L.1)
9. Develop a process that will enable the primary care physician to address all chronic care conditions on a regular basis. (Provision L.1)
10. Develop additional medical audit elements that represent the most common and serious medical conditions that occur in individuals with intellectual disabilities. (Provision L.2 and L.3)
11. Ensure that internal and external medical audit findings are used to assist in improving the physicians' performance, by including results of the audits in an administrative review., (Provision L.2 and L.3)
12. Develop and implement clinical policies, procedures, and/or guidelines for all clinically relevant systems at the Facility. (Provision L.4)
13. Ensure that quality medical indicators, that represent outcome measures for common and serious medical conditions, are developed for a medical quality assurance process. (Provision L.3)

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Section M Self-Assessment, Updated: 4/29/13 2. RGSC Section M Action Plans, Updated: 4/25/13 3. RGSC Section M Presentation Book 4. Texas Department of Aging and Disability Services (DADS), Medication Variances Policy, Policy Number: 053, Date Effective: 9/23/11 5. DADS Nursing Services Policy, Policy Number: 010.2, Date Effective 9/20/12 6. RGSC Nursing Services Policy, Standard Operating Procedure NR 400-01, Date Established: Revised: May 2013 7. RGSC Medication Error Policy, Standard Operating Procedure NR 200-66, Date Established: September 1998 (revision date not provided) 8. RGSC Pharmacy Policy, Medication Error Report, Standard Operating Procedure PH 100-017-01-09, Date Revised: March 2011 9. RGSC Pharmacy Policy, Administration of Medication, Standard Operating Procedure PH 100-018-01-03 (mm-06.01.011), Date Revised: March 2011 10. RGSC Emergency Response Policy, Standard Operating Procedure, ICF-DD 100 18, Date Established: 9/23/10 11. RGSC Environmental Surveillance Techniques, Standard Operation Procedure EC403-03, Date Revised: October 2011 12. RGSC Infection Control Monthly Report, Standard Operating Procedure EC402-03, Date Revised: October 2011 13. RGSC Quarterly Data Tally Sheet Performance Improvement Indicators, Standard Operating Procedure EC401-05, Date Revised: October 2011 14. RGSC Environment of Care Manual and Surveillance, Prevention, and Control of Infection Manual Table of Contents 15. RGSC Morning Medical Meeting Reports, 4/4/13 through 5/10/13 16. RGSC Completed Emergency Drill Checklists, October 2012 through February 2013 17. RGSC CTD Individual Training Records for Nursing, From: 1/1/10 through 4/30/13 18. RGSC Summary of Nursing Staffing Reports, From: 8/1/12 through 3/1/13 19. RGSC Nursing Staffing Analysis by Shift: October 2012 through January 2013 20. RGSC Nursing Staffing Schedule for Full-time and Agency Nurses, For: April 2013 21. RGSC RN Case Manager Caseloads, For: March 2013 22. RGSC Minimum Staffing Levels by Shift 23. RGSC Nursing Hours of Overtime and Contract Hours, From: October 2012 through January 2013 24. RGSC Nursing Meeting Minutes: 9/20/12, 10/10/12, 10/18/12, 11/15/12, 11/30/12, 12/21/12, 1/9/13, 1/18/13, and 3/21/13 25. RGSC Safety/Risk Management/Infection Control Committee Meeting Minutes, For: 9/13/12, 10/18/12, 11/15/12, 12/13/12, 1/18/13, 2/14/12, 3/21/13, and 3/21/13 26. RGSC Departmental Performance Measures – Infection Prevention and Control/Employee Health, Q2FY13

	27. RGSC Infection Control Reports: August 2012, September 2012, October 2012, November 2012, December 2012, and January 2013, 28. RGSC Infection Control Environmental Surveillance Reports: August 2012, September 2012, October 2012, November 2012, December 2012, January 2013 29. RGSC Zoster Vaccinations Documentation Report, including Signed Vaccination Consent Sheet, 8/13/12, 30. RGSC Follow-up on Immunization Administration, 9/25/12 31. RGSC Action/Corrective Action Reporting Documentation Meeting (Reporting Team/Program Area) Minutes, for Zoster Vaccinations and Vaccination Monitoring on 11/15/12 and for Influenza Vaccinations on 11/16/12 32. RGSC Memorandum Regarding Pneumococcal Vaccines, 12/3/12 33. RGSC Antibiograms Adapted from Valley Baptist Medical Center, January through December 2011 34. RGSC Infection Control Curricula and training material, revised: 11/10/11 35. RGSC Comprehensive Preventive Health (Immunizations) Database, Printed: 4/8/13 36. RGSC Competency Development and Training (CDT) Course Due/Delinquency List for Infection Control Training 37. RGSC Individual Notebook Audits for March 2013 and April 2013 38. RGSC Preventative Work Order for Emergency Equipment, September 9/4/12, 10/1/12, 11/8/12, 12/3/12, 1/4/13, and 2/6/13 39. RGSC Emergency Checklist Analysis Summary: October 2012 through March 2013 40. RGSC Emergency Response Instructor Training and Competency Exam Training/Course Sign-In Sheets and Drill Instructors Check-off Sheets, 3/1/12 41. RGSC CDT Course Due/Delinquent Lists for Health Care Providers Cardiopulmonary Resuscitation (CPR)and Automated External Defibrillator (AED) Training and CPR Basic Training, 3/26/13 42. RGSC Pharmacy and Therapeutics Committee Meeting Minutes, 9/26/12 and 12/19/12 43. RGSC Physical Nutritional Management Committee Meeting Minutes, 3/26/13 44. RGSC Chemotherapy Plan of Care Review, Training Course Sign-In Sheets, 1/23/13 45. RGSC Nursing Education Summary, October 2012 through March 2013 46. RGSC Summary of Medication Variances, October through March 2013 47. RGSC Intermediate Care Facility (ICF) Telephone Order Audits, November 2012, December 2012, January 2013, February 2013, March 2012, and April 2013 48. RGSC E-mail from State Nursing Services Coordinator Regarding Clarification on Integrated Health Care Plans (IHCPs) and Acute Care Plans (ACPs), 5/14/13 49. RGSC Review of 13 Bowel Elimination Monitoring Bar Charts for Individuals #2, #139, #77, #143, #132, #118, #62, #66, #98, #29, #72, #55, and #79 50. RGSC Review of 17 Aspiration Trigger Data Sheets for May 2013, for Individuals #150, #4, #19, #79, #94, #108, #36, #132, #85, #126, #47, #72, #143, #29, #67, #118, and #97 51. RGSC Review of Change of Diet Orders, and Training Rosters, September 2012 through April 2013, for Individuals: #94, #60, #29, and #74. 52. RGSC Review of Nine Most Recent Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plan (IHCPs) for Individuals: #55, #98, #101, #114, #66, #5, #47, #11, and #79 53. RGSC Comprehensive Record Review for Individuals: #79, #126, #19, #24, #115, #62, #108, #118,

	and #72 **People Interviewed:** 1. Yolanda Gonzalez, Chief Nurse Executive (CNE) 2. Robin Martin, RN BSN, MSN, Nursing Operations Officer (NOO) 3. Hilaree Mariboa, RN, Unit Nurse Manager 4. Jamie Rodriguez, RN, RN Case Manager 5. Eva Lujano, RN, RN Case Manager 6. Judith Tamez, RN, RN Case Manager 7. Terra Garza, RN, RN Case Manager 8. Jessica Juarez, RN, Infection Control Preventionist (ICP) 9. Roger Garza, Jr. RN, Supervisor (contract RN) 10. Michael Robinson, RN, Quality Enhancement Nurse (QE) 11. Maria Dill, MD, Medical Services 12. Lorraine Hinrichs, IFC-IDD Program Director 13. Numerous Staff Nurses and Direct Care Professionals **Meetings Attended/Observations:** 1. Review of Section M Presentation Book with Chief Nurse Executive, Nurse Educator/Unit Nurse Manager, RN Case Managers, and Quality Enhancement Nurse, 5/13/13 2. Review of Infection Control Program with Infection Control Nurse and Dr. Maria Dill, 5/13/13 3. Medication Administration Observations in La Paloma and El Paisano 4. QA/Death Review Meeting with QA Director, 5/14/13 5. Morning Medical Meeting, 5/14/13 6. SA-PIC Business Meeting, 5/14/13 7. ISP Preparation Meeting for Individual #48, 5/15/13 8. Pharmacy and Therapeutics Meeting, 5/15/13 9. Numerous tours in La Paloma and El Paisano throughout the compliance review
	Facility Self-Assessment: For Section M, in conducting its self-assessment, the Facility: ▪ Used the statewide Facility Self-Assessment Monitoring Tools. The monitoring/audit tools the Facility used to conduct its self-assessment included: Nursing Care Monitoring Tool Audits, Mock Medical Drill Audits, and Medication Administration Observation data. ▪ These monitoring/audit tools included sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement. ▪ The monitoring tools included sufficient methodologies, such as observations, interviews, record reviews to determine status of compliance with the respective monitoring processes. ▪ The Self-Assessment did not identify the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall. The sample sizes were adequate to consider them representative samples. The number for percent of sample size of individuals/records as compared to the overall population was not included in the Self-Assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was provided by months, quarters, and overall percentage of compliance. Although

	this information was not provided, the Facility had a formalized procedure for conducting monitoring and/or observing each tool. ▪ The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. The following staff/positions were responsible for completing the audit tools included: The Chief Nurse Executive, Nursing Operations Officer, Quality Enhancement Nurse and Unit Nurse Manager. ▪ An inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools. However, it was not yet sufficiently in place to assess the inter-rater reliability of all nursing monitoring/audit tools used by the Facility. ▪ The Facility used other relevant data sources and/or key indicators and/or outcome measures. For example, these included databases that showed the percentage of nurses who had completed required training classes and Medication Variance database, and the Comprehensive Preventative Health Database that tracked preventative health follow-ups and immunizations. ▪ The Facility consistently presented data in a meaningful and useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. The data provided an indication of the areas of strength, weakness, or the status of progress. The indicators clearly identified what was being measured or the criteria used for measurement. o Consistently measured the quality as well as presence of items. o Distinguished data collected by the QA Department versus the Nursing Department. The Facility's Self-Assessment stated they were not in compliance with Provisions M.1, M.2, M.3, M.4 and M.5 and were in substantial compliance with Provisions M.6. The Monitoring Team did not concur with their findings. None of the provisions were found in substantial compliance.
	Summary of Monitor's Assessment: In general, some appreciable progress had been made in improving the integration of the Morning Medical Meetings and improving and expanding the Clinic Appointment Database. The Emergency Response system and Infection Control Program had maintained the positive practices found in the previous compliance review. However, the Nursing Department's ability to move forward toward compliance with provision related to nursing assessments and documentation appeared to have been hampered by the significant turnover in nursing administrative and management staff. Provision M.1: The Facility had made several improvements for the management and integration of individuals who experienced acute changes in health status. Facility continued to conduct and to expand the integrated participation of staff attending meetings. The Medical Morning meeting participants included: The Medical Director who chaired the meeting, staff, Psychiatrist, Psychologist, Behavior Analyst, CNE, NOO, QE Nurse, PNMT Nurse, Unit RN Case Managers, Clinic Nurse, QDDP Supervisor, Unit QDDPs, Speech Therapist, PNMT Director, Dietitian, Program Improvement Specialist, Unit Directors, and recorder. All participants actively participated. The meetings now had a daily agenda published and minutes were kept of the meetings.

	The clinic clerk had done an outstanding job improving and expanding a robust Appointment and Tracking Database to not only schedule clinic and consult appointments and to reschedule missed appointments, but also to capture and retain individuals' historical data regarding dates and types of past appointments/consults. The Nursing Department needs continued improvement to ensure that all Nursing Monitoring Tools and other audits are completed timely, accurately and according to the schedule, and then turned in timely to the Quality Enhancement Department. The Facility needs to enhance the inter-rater reliability process between monitoring/audits completed by the Nursing Department and the Quality Enhancement Nurse. The Facility continued to comply with the Emergency Response Policy. Mock Medical Drills were completed as scheduled; corrective action was taken on failed drills. Mock Medical Drill data were presented at the Risk Management/Infection Control Committee and Incident Management Committee Meeting. Emergency equipment and Automated Defibrillators were checked daily by the nursing staff and monthly Emergency Equipment Walkthroughs were completed by the risk management staff. The Infection Control Preventionist continued to maintain an excellent Infection Control Program, with the exception of following-up on the Acute Care Plans developed and implemented by the nursing staff for "real time" reported infections to ensure they included all relevant preventive measures for the identified infectious/communicable diseases. She maintained an excellent Comprehensive Preventative Health Database that tracked preventative health follow-ups and immunizations. The Safety/Risk Management/Infection Control Committee regularly met monthly and reviewed/discussed infection control issues. The Nursing Department experienced significant turnover of the Nursing Operations Officer, Nurse Educator and Unit Nurse Manager, all of which were recently replaced. This no doubt had a significant negative impact on their ability to ensure compliance with the requirement for the assessments and documentation of individuals who experienced acute changes in health status. It is expected with hiring the new leadership staff, the Nursing Department will be able to move forward for compliance with assessments and documentation of individual who experience acute changes in health status. The Monitoring Team did not find this provision yet in substantial compliance. Provision M.2: The Nursing Department had recently hired two additional RN Case Managers which reduced the average caseload from more than 30 individuals to approximately 15. This should help with the timeliness, content, and quality of the nursing assessments. All of the RN Case Managers and RNs were reported to have attended the State Office mandated Physical Assessment and Documentation Class, as well as training provided on the revised Integrated Risk Rating Form and Integrated Health Care Plan process. The RN Case Managers were attending the Morning Medical Meetings, reviewing the 24 Hour Nursing Shift Log, and attending Nursing Shift Reports. All these combined efforts should help the Nursing Department move forward toward compliance with this provision. Provision M.3: The Acute Care Plans were not being consistently developed for acute changes in health

	conditions as required by the revised Integrated Risk Rating Form and Integrated Health Care Plan processes. This was primarily due to the nursing staff's confusion as to when Acute Care Plans were required. This issue was clarified by the State Office Coordinator. The Health Maintenance Plans were no longer used and were beginning to be replaced by the Integrated Health Care Plans. Provision M.4: The loss of the Nurse Educator hampered the Nursing Department's ability to keep up and track all required nursing training, although the Nursing Operations Officer had made a valiant effort to continue to provide training to the nursing staff. A new Nurse Educator was expected to be hired the week following the compliance review. The nurse's credentials as a Bachelor of Science in Nursing and a Master's of Science in Nursing degrees should prove a valuable asset in organizing, managing, and training the nursing staff. The Nurse Educator needs to develop a centralized system for tracking all nursing training. There is a continuing need to reinforce training on the nursing assessments and documentations, as well as on the nursing protocol cards. It is essential that nursing protocols are implemented sufficient to meet individuals' health care needs before substantial compliance can be achieved with this provision. The Monitoring Team did not find RGSC yet in substantial compliance with this provision. Provision M.5: A review of the records showed the IRRF and IHCP processes were continuing to evolve, but were not yet fully implemented and proficient in assessing risk ratings. The IRRF form had been revised to include six clinical risk groups: The effort to group interrelated conditions into six groups was a positive start. However, the interrelationship of risk conditions does not yet seem to be fully realized. The IHCPs were beginning to be developed and implemented but need continued improvement to sufficiently integrate all aspects of care related to the identified risk ratings. Provision M.6: The Facility had made general improvement in the organizing and managing of medication administration practices in keeping with generally accepted standard of practices. The Medication Workgroup Committee and Pharmacy and Therapeutics Committee met regularly as scheduled. These committees need to conduct a more in depth review of medication variances and ensure that local as well as systemic corrective actions are taken to mitigate medication variances. There was a continued need to enhance Medication Administration Observations, Medication Room Audit, and Medication Administration Record Audits. All medication variances committed by the responsible disciplines must be reported and corrective action provided when necessary. The Facility must ensure that all medication variances are reported. The Facility stated they were in substantial compliance with this provision. The Monitoring Team did not find this provision yet in compliance.

#	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	<u>Monitoring Team Findings:</u> The Monitoring Team validated the information presented in the Facility's Self-Assessment through: Review of the information presented in Section M.1 Presentation book. Review of documents requested: Meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, Quality Enhancement Nurse, Unit Nurse Manager, and RN	Noncompliance

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	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.	Case Managers; and review of individuals' records; and observations. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were not in substantial compliance with Provision M.1 and the Monitoring team concurs with their findings. This Provision of the Settlement Agreement includes a number of requirements that address various areas of compliance. These requirements include: staffing, quality assurance efforts, assessment and documentation of individuals with acute changes in status, availability of pertinent medical records, infection control, and mock medical drills and emergency response system. Additional information regarding the nursing assessment, development, and implementation of health care plans is found below in Provisions M.2 and M.3 reports. Information and recommendations regarding nursing documentation on restraint usage is included above in Provision C.5 of the report. <u>Staffing</u> At the time of the compliance review the Facility census was 63. The Nursing Department had 21 budgeted nursing positions, of which there were 13 RNs and eight LVNs. The Nurse Educator position was vacant. The CNE position was not included as one of the 21 nursing positions. Of the RN positions, one served as the Quality Enhancement Nurse and another served as the Physical Nutritional Management Team (PNMT) Nurse, which were not counted as part of nursing services' staffing. Twenty RN and/or LVN agency nurses were used to supplement vacancies and fill in for staffing shortages. The PNMT Nurse also served as the Hospital Liaison Nurse. The Infection Control Preventionist was responsible for the Infection Control Programs for the Intermediate Care Facility, Mental Health Hospital, and Out Patient Clinic. As was found last compliance review, the Nursing Department continued to have a significant turnover rate of nursing administrative and management staffs. Since the last compliance visit, the Nursing Operations Officer, Unit Case Manager, and two additional RN Case Managers had recently been hired. Functional job descriptions of these staff were provided for review. The Quality Enhancement Nurse was in the process of leaving because he had taken a job as the CNE at another State Supported Living Center. The Nurse Educator position was vacant. Interviews were being conducted to replace both of these nursing positions. The Nurse Educator was expected to be filled 5/20/13. Once the Nurse Educator and Quality Enhancement Nursing positions are filled, the Nursing Department should have sufficient administrative and management staff, provided there is retention of the recently hired staff. It was apparent from observations, interviews, and review of documents that this high turnover rate had a significant negative impact on moving the Nursing Department forward in complying with each of this section's provisions of the Settlement Agreement.	

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		However, it was evident that the recently hired administrative and management staff were highly motivated and dedicated to re-establishing the administrative and managerial functions of the Nursing Department. The numerous staff nurses interviewed on the units also showed a high degree of dedication and commitment in providing quality nursing care. Most of the nurses interviewed were agency nurses. They would be a positive asset to nursing service if they could be recruited for full-time employment. According to the CNE and NOO it was difficult to recruit them because their salaries were higher than the State's salaries. It was positive to find that the two RN Case Manager positions that had been eliminated at the last compliance review had been re-established and the Nursing Department now had four RN Case Managers; this should be sufficient to case manage 63 individuals' health care needs, based on the other State Supported Living Centers' average caseload ratio of 1:15 for medically fragile individuals. Individuals who reside in La Paloma were primarily medically fragile. Individuals residing in El Paisano have primary focus on behavior support plans. The Nursing Operations Officer had completed a comprehensive staffing analysis and determined that additional 18 staff nurses were needed to sufficiently cover 24 hours a day, seven days a week. The Facility administrative staff stated they were in the process of considering contracting with a private nursing staffing agency for 18 full time nursing positions. The addition of these nursing positions was a positive step forward and should further strengthen nursing services' ability to provide health care services. The Monitoring Team's review of the nursing staffing analysis, by month, by home, and by shift, August 2012 through March 2013, showed none of the shifts had fallen below the establish minimum staffing ratios. This was a positive finding considering the limited number of staff nursing positions available, including agency nurses. <u>Quality Enhancement Efforts:</u> The Facility's Self-Assessment report the review of nursing assessments for timeliness of completion and monthly authentication for the past six months showed: Month / Percentage of Compliance August 2012 / 100% September 2012 / 72% October 2012 / 81% November 2012 / 95% December 2012 / 77% January 2013 / 100%	

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		The Facility's Self-Assessment report the review of Annual Nursing Assessments for September 2012, October 2012, and November 2012 Showed: Month / Percentage of Compliance September 2012 / 66% October 2012 / 78% November 2012 / 96% The additional Nursing Monitoring Tool data provided for review included: A bar graph for overall compliance of all 12 monitoring tools, 9/1/12 through 2/28/13. The graph did not include a narrative explanation of the nursing monitoring data represented or the percentage of compliance related to the overall data. Graphs were included by month, items on various monitoring tools, by auditor and percentage of compliance found by each auditor, graphs for each home overall percentage of compliance, graphs by individuals' audited and percentage of compliance, and a list of items on the Medication Administration and Documentation that fell below the 90% threshold. There were no CATW2's because none of the monitoring tools fell below 90%. This data was extremely confusing and impossible to understand and interpret in surmising the overall status of compliance with all 12 nursing monitoring tools. There was no overall inter-rater reliability data provided for review, although it was reported that the Quality Enhancement Nurse conducted such checks. In approximately February 2013, the State CNE Nursing Workgroup had decreased the number of Nursing Monitoring Tools to six with revisions made to some of the tools. The workgroup also developed Protocol Card Audit Tools for each of the nursing protocols, for which the Facilities could select which Protocol Card Audit tools they wished to use. No data was yet available for review on the six revised Nursing Monitoring Tools or the selected Protocol Card Audit Tools. According the RGSC schedule for May, June, and July 2013, the RN Case Managers were assigned to monitor the Nursing Monitoring Tool for Annual Nursing Assessments, and the Respiratory Distress/Aspiration and Constipation Protocol Card Audits. The frequency, size of sample, how and by whom the sample was selected for these tools were not included. The Infection Control Preventionist was assigned to complete four Infection Control Monitoring Tools; however, the frequency, how and by whom the sample was selected was not included. The Unit Nurse Manager was assigned to complete the Medication and Documentation Monitoring Tool quarterly; however, the size of sample, how and by whom the sample was selected for this tool was not included. The Nursing Department reported the following reports/audits were conducted: • Injury Reports were entered by the Medical Hospital Liaison Clerk on a daily basis for Incident Management Team (IMT) Reporting and sent to the IMR every morning.	

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		Weekly reports were submitted as needed to relevant parties for finalization. • Emergency Equipment Checklist, Oxygen Tanks, and AED Machines were checked daily by the night nurse in each dormitory, in Vocational Education area, the La Paloma medication nurse checks all equipment from the first to the fifteenth of the month. The El Paisano medication nurse checks the other emergency equipment. By the end of the month all checklists were placed in the clerk's inbox for filing. • Monthly Submissions were due by the fifth of the month by the RN Case Managers. The reports were emailed to the clerk for final reporting. What was included in the monthly submissions was not described. • Critical Labs were due by the fifth of the month. These reports were completed by the clerk. • ER Visits/Hospitalizations Reports due by the fifth of the month. These reports were completed by the Nurse Liaison. • Monitoring Tools were due by the fifth of the month. These tools were completed by the RN Case Managers. All completed information was forwarded to the Nurse Liaison for final reporting and filing. • Staffing Analysis reports were due by the 20th of the month. These reports were completed by the clerk. • Monthly Audits were due two weeks after the end of month by the Unit Nurse Manager. The monthly audits referred to were not described. Except for the nursing monitoring tool data, medication administration observations, staffing analysis, emergency equipment checklist, and appointment audits, other outcome data were not provided for review. The Quality Enhancement Department needs to enhance inter-rater reliability checks on all nursing monitoring and audit tools, as well as Medication Observations. As was found at the last compliance review, the Nursing Department's efforts for completing quality enhancement activities showed no appreciable improvement. Therefore, the nursing monitoring tool data was not yet reliable to measure compliance with the Nursing Monitoring and Protocol Card Audit tools. 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 and Protocol Card Audits 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. <u>Assessment and Documentation of Individuals with Acute Changes in Status:</u> • The Monitoring Team attended the Medical Morning Report on 5/14/13, and	

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		validated that since the last compliance review, the Facility had continued to conduct and to expand the integrated participation of staff attending the meetings. The Medical Morning meeting participants included: The Medical Director who chaired the meeting, staff, Psychiatrist, Psychologist, Behavior Analyst, CNE, NOO, QE Nurse, PNMT Nurse, Unit RN Case Managers, Clinic Nurse, QDDP Supervisor, Unit QDDPs, Speech Therapist, PNMT Director, Dietitian, Program Improvement Specialist, Unit Directors, and recorder. All participants actively participated. The meetings now have a daily agenda published and minutes are kept of the meetings. The Clinic RN provided a 24 hour nursing report. Additionally, the meeting agendas typically covered the following items: o Items covered under old business: Continuation of previous day's business, approval of previous day minutes, pending or unfinished business. o Items covered under new business on each home: Hospitalizations, emergency room visits, x-rays and test results, critical labs (recap), restraints medication/treatment refusals, pre-treatment sedation, changes in level of supervision, IDT referrals, nurse referrals, clinic and/or consult appointments, consult results, new or updated diagnoses, psychiatric recommendations, skin integrity issues, infection control issues, aspiration pneumonias when applicable, and any additional items needing attention from the morning medical team members and disciplines. This was validated through the Monitoring Teams' review of the Morning Medical Meeting Report minutes, 4/4/13 through 5/10/13. • The clinic clerk had done an outstanding job improving and expanding a robust Appointment and Tracking Database to not only schedule clinic and consult appointments and to reschedule missed appointments, but also to capture and retain individuals' historical data regarding dates and types of past appointments/consults. Daily appointment schedules and reports are provided to the respective disciplines and IDTs for review and follow-up. Weekly Appointment Schedules and analysis, with respective CATW2s for missed appointments, were provided for: 4/1/13 through 5/3/13. For example: the week of 4/29/13 through 5/3/13 showed: Fourteen appointments were scheduled, 13 appointments were kept, and the one appointment that was not kept was rescheduled. The reason for the failure to keep the appointment was documented and a CATW2 was completed for the missed appointment. • The Nursing Department reported they had implemented a process for daily assessments of five randomly selected individuals per shift per home. A summary of this assessment process included: o Every morning the floor nurses review orders, recent changes in level of supervision, diet changes, medication orders, weights, vital signs, and precautions. The nurse updates the MiniKardex with the information. o The five randomly selected individuals or those who needed nursing	

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		assessments per the morning report were assessed for: Vital Signs and oxygen saturation levels and when indicated focus assessments were completed for specific conditions, the assessments were completed according to the respective nursing protocol cards. Comprehensive nursing assessments were completed when indicated. The respective physicians were notified as indicated. If individuals had no bowel movements for two to three days and/or stool was found in the rectal vaults and there were no per necessary (PRN) orders for laxatives and/or suppositories, the respective physicians were notified. If there were no results from the PRN orders or there were problems identified upon abdominal assessments, the respective physicians were notified. Although this practice appeared promising, it only included five individuals each shift per home. The RN Case Managers stated, with their limited nursing resources it was not possible to complete a daily assessment on each individual. The Monitoring Team was not provided supporting documentation to validate this process but plan to review documentation at the next compliance visit. In general, although facility-wide systems had been put in place to improve the integration and management of acute change in individuals' health status, as was found in previous compliance review, there was no appreciable improvement found in nursing's assessments and documentation of individuals with acute changes in status. From a review of individuals' records the following problematic trends continued to be found: • Lack of documentation in the Integrated Progress Notes and other records made it difficult to determine when changes in health status initially occurred. • Lack of consistent focused nursing assessments in individuals' response to presenting signs and symptoms of acute changes in status, and/or changes in vital signs and oxygen saturation measurements as well as lung and/or bowel sound assessments for respiratory and gastrointestinal issues, when indicated. • Lack of follow-up of issues noted in previous nurses' progress notes. • Lack of specific description of physical appearance, size, and location of skin rashes, injuries and/or bruises. • Lack of documentation regarding activity tolerance for activities during the day for individuals' experiencing or recovering from an acute illness or injury or seizure activities. • Inadequate documentation of the administration and follow-up response of PRNs (as needed medications). • Lack of mental status assessments documented during status changes and/or specific descriptions when individuals were engaging in maladaptive behaviors. • Significant gaps in documentation when the nurses' notes stated, "will continue to	

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		monitor." The nurses consistently failed to state what would be monitored and the frequency of the monitoring. • Lack of documentation that there was communication with other relevant disciplines when there were acute changes in individuals' health or behavior status. • Inconsistent development and implementation of Acute Care Plans (ACPs) for individuals who experience acute changes in status. • Lack of analysis of contributing problematic issues affecting acute changes in status. • Lack of consistent documentation in the Integrated Progress Notes when ACPs were initiated. • Lack of documentation through to resolution for acute changes in status. • Lack of consistent adherence to Nursing Protocols. • Late entries were frequently documented in the Integrated Progress Notes. • Annual and Quarterly Comprehensive Nursing Assessments were not revised to reflect significant changes in status or new problems until the next assessments were completed. <u>Availability of Pertinent Medical Records</u> • 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. • As was found in previous reviews, the Facility did not include health care plans instruction sheets for direct support professionals in individuals' Individual Notebooks because they did not have a record number. It is essential that the Individual Notebooks include health care plan instruction sheets for the direct support professional to follow in providing care. • Universal Signature Sheets in the Medication Administration Record Notebooks for nurses responsible for administering medications were not updated when nurses leave or when new nurses were added. Most of the nurses' signatures, titles, and initials were illegible. It is essential that the Universal Signature Sheets are kept up-to-date and that the nurses' signatures, titles, and initials are legible. • Integrated Progress Notes were not consistently documented in the Subjective, Objective, Assessment and Plan (SOAP) format when indicated for assessment related clinical data. <u>Hospital Liaison Nurse Activities:</u> At the time of the compliance visit, the PNMT Nurse also served as the Hospital Liaison Nurse. The Nursing Staff continue to maintain contact with hospital personnel during individuals' hospitalizations. Documentation of the hospital contact notes were included in the Client Work Station that was accessible to relevant IDT members. The Facility	

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		reported the IDTs were conducting Pre and Post Hospitalization Discharge Planning Meetings. There were no individuals hospitalized at the time of the review. The Monitoring Team's review of nine individuals' records showed that six of nine (67%) individuals were hospitalized and/or had emergency room visits over the past three months. It was positive to find some improvement in compliance with the When to Notify the Primary Care Physician Nursing Protocol and the Nursing Hospitalization, Transfer, and Discharge Policy, with the following exceptions: For emergency room visits the nurse to nurse call to the emergency room that individuals were in transit was not consistently completed until after their arrival at the emergency room. There was documentation in the Integrated Progress Notes that RN Case Manager, NOO, and/or the PNMT Nurse maintained almost daily contact with hospital personnel regarding individuals' health status either by onsite visits to the hospital or by telephone contacts. For example: On 3/17/13, Individual #40 was admitted to the hospital and diagnosed and treated for dehydration and sepsis related to a urinary tract infection. Throughout his hospital stay there was daily contact documented in the Integrated Progress Notes by the RN Case Manager, NOO, and PNMT Nurse. Individual #40 was discharged on 3/26/13. A Post-Hospitalization Nursing Assessment was completed upon return from the hospital. A comprehensive Post Hospitalization Assessment/Evaluation by the PNMT Nurse was documented in the Integrated Progress Notes. Upon return an Acute Care Plan for Urinary Tract Infection was implemented. <u>Infection Control Activities</u> The Infection Control Preventionist continued to maintain a robust Infection Control Program. An interview with the Infection Control Preventionist and Dr. Dill, along with a review of documents found: Policies and Procedures: The Monitoring Team was provided with copies of the following Infection Control Policies: • Quarterly Data Tally Sheet Performance Improvement Indicators, Standard Operating Procedure EC401-05, Revised: October 2011 • Infection Control Monthly Infection Report, Standard Operating Procedure EC402-03, Revised: October 2011 • Environmental Surveillance Techniques, Standard Operating Procedure EC403-03, Revised: October 2011 • According to the next review/revision date for October 2012, the above policies are overdue for annual review/revision and should be updated. • The Infection Control Preventionist stated a new Texas Department of Aging and Disability Services and Department of Health Services, Determination of Occupational Risk Policy, Date: September 2012 had been operationalized. A copy	

#	Provision	Assessment of Status	Compliance
		was requested but not received. RGSC Vaccine Preventable Disease Policy was also requested but not received. The Facility follows the Centers for Disease Control and Prevention's immunization schedule. Infection Control Training: • The Facility reported that all employees were current with Infection Control refresher training. Infection Control training continued to be provided in New Employee Orientation (NEO). • Seventeen of 21 (81%) nursing staff were competency-based trained on Multi-Drug Resistant Organisms (MDROs) Precautions. Eight non-nursing employees were also trained. Infection Control Committee Meetings: • Six of six (100%) scheduled monthly Safety/Risk Management/Infection Control Committee meetings were conducted. • The Safety/Risk Management/Infection Control Committee Meetings were combined meetings with the Facility, Mental Health Hospital, and Outpatient Clinic staff. Therefore, it was not possible to accurately evaluate consistent attendance of all core members for the Facility. • The Infection Control Preventionist consistently analyzed and trended infections and reportable diseases and reported the results to the September 2012 through February 2013, Safety/Risk Management/Infection Control Committee. The infections and reportable disease data were included in the minutes. No infectious or communicable disease trends were identified during the reporting period. The Facility continued to use the following criteria for identifying and tracking trends: • The Monthly Infection Reports included total number of infections, percentage rate of overall infections, percentage rate of Healthcare-Associated Infections and listed types of infections. The Centers for Disease Control and Prevention (CDC) criteria was used for calculating rate of Healthcare-Associated Infections. The criteria established by the Texas Department of Health Services for State Mental Health Hospitals was used to determine the percentage rate of Healthcare-Associated Infections to indicated trends. The percentage rate of Healthcare-Associated Infections was determined by an annual average percentage rate from all state Mental Health Hospitals. A percentage rate of Healthcare-Associated Infections of 11% or greater for a specific infection was considered a trend. Infection data reported cases of skin and soft tissue MRSA infections in La Paloma in December 2012 and January 2013. There was documentation that the Nurse Educator provided staff training on preventative measures or put other measures in place in La Paloma to prevent spread of infection. Seventeen of 21 (81%) nursing staff were competency-based trained on Multi-Drug Resistant Organisms (MDROs) Precautions.	

#	Provision	Assessment of Status	Compliance
		Eight non-nursing employees were also trained. • The Infection Control Preventionist consistently conducted monthly handwashing observations and environmental surveillance rounds in all areas of the Facility. Corrective action was taken with follow-up for deficiencies found in handwashing observations and environmental surveillance rounds. These data were analyzed and trended, reported, and included in the Safety/Risk Management/Infection Control Committee Meeting minutes. <u>Other Infection Control Activities:</u> • The Comprehensive Preventative Health Database was maintained and updated monthly. This database not only tracked each individual's immunization status; it also provided the Facility's overall percentage of completion for each required immunization. The 5/13/13 immunization data for El Paisano showed an overall 100% completion for immunization except for: Zoster vaccinations were reported at 93% completion and Hepatitis B vaccinations at 97%. One individual due for the Zoster vaccine had just turned 50 years of age and the order for the vaccination had not been written. Another individual who was due Tdap (combined tetanus, diphtheria, and pertussis) vaccination was deferred by the physician due to medical compromise and suppressed immune system. Immunization data for La Paloma showed an overall 100% completion for immunizations except for: Hepatitis B at 93%. There was no explanation provided explaining why the Hepatitis B vaccinations were not 100% completed. In addition, the Comprehensive Preventative Health 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 100% completion for both La Paloma and El Paisano. There was documented evidence that the Comprehensive Preventative Health Database 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. Notifications of due/delinquent immunizations and/or preventative health follow-up were sent to individuals' respective physicians and RN Case Managers. • Since the last review, it was positive to find that the Facility had contracted in April 2013, with a Gynecologist to provide Women's Health. The Infection Control Preventionist completed a 100% chart review on female individuals and identified their women's health care needs for routine assessments and follow-up and	

#	Provision	Assessment of Status	Compliance
		appointments were scheduled by the Outpatient's Women's Health Care Nurse. The women were seen by the Gynecologist at the Outpatient Clinic. Women who require sedation for examinations were seen by the Gynecologist at the local hospital. The reports of the examinations were sent to the Facility physicians by the Women's Health Care Nurse. • The Infection Control Preventionist 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. In addition, physician orders were faxed to her for all infections. There was no data provided to verify that "real time" infections were investigated. The need for "real time" reporting of infections was discussed. As was discussed at previous compliance reviews, it is essential that the Infection Control Preventionist provide technical assistance to the nursing staff by reviewing their Acute Care Plans for infections to ensure they include preventative measures, assist the nursing staff put preventative measures in place, and provide staff training to prevent the spread of infectious and communicable disease. Refer to Provision M.3 for a review of individuals' ACPs who had infections. • Of the 63 individuals, 100% were current with influenza vaccinations. • Of the 63 individuals, 100% were compliant with tuberculosis skin testing or chest x-rays. There were no tuberculosis converters reported. • Of the employees, 95% were vaccinated with influenza vaccinations. Five percent of the employees signed influenza vaccination declination forms. • Of the employees, 100% were current with tuberculosis skin testing or questionnaires. • Of the employees, 100% of the employees identified as high risk were vaccinated with the Hepatitis B series or were in the process of completing the Hepatitis B series. • The Facility reported all employees were current in annual refresher Infection Control training. • The infection Control Preventionist maintained a monthly Antibiogram of Antibiotic Susceptibility of Common Organisms Reports, attended the Pharmacy and Therapeutic Committee Meetings, and shared the information with the Pharmacist and physicians. • The Infection Control Program provided the nursing staff with a Transmission Based Precautions Quick Reference Guide card to wear on their lanyard as a reminder for following standard precautions for contact with infectious/communicable diseases. • The Infection Control Preventionist had received continuing education by participating in the following: Centers for Disease Control and Prevention, (Webcast) Immunization Update 2012 on 8/16/12 and Association for Professionals in Infection Control and Epidemiology on 12/23/12.	

#	Provision	Assessment of Status	Compliance
		Skin Integrity Activities As was found at the last review, the Nursing Department did not have a system in place to track skin break down/decubitus. Neither did they have a dedicated Skin Integrity Nurse. The Nursing Department reported a Skin Integrity Committee Meeting was conducted for the first quarter in March 2013. However, the minutes of the Skin Integrity Committee Meeting minutes were not available for review. Neither was documentation provided that described the purpose/function of the committee or a list of core membership. The Monitoring Team requested a list of individuals with decubitus/pressure ulcers and/or skin integrity issues. The Facility reported there were no individuals diagnosed with pressure ulcers. One individual was identified with skin integrity issues. Individual #126 had excoriation of the anal regions secondary to relaxed anal sphincter. The Monitoring Team observed wound care provided by the nursing staff, who followed physician orders and completed proper technique for wound care. The Skin Integrity Committee should develop and implement a monthly and longitudinal tracking system for all stages of pressure ulcers, as well as use the Pressure Ulcer Scale for Healing (PUSH) method for assessing pressure ulcers. Medical Emergency Response Activities: Since the last review the Facility had continued to make progress toward meeting the requirements of the Medical Emergency Response, Standard Operating Procedure, ICF-DD 100 18, Revised: 9/22/11 and the adopted Texas Department of Aging and Disability Services, Emergency Response Policy, 044, Dated 9711. The Vocational Services Coordinator continued to be responsible for scheduling, conducting, reporting, and tracking Mock Emergency Drills. He ensured drills were completed according to the Facility's Emergency Response System Policy. • A review of the monthly Medical Emergency Drills completed for September 2012 through February 2013 showed that 100% of the scheduled drills were completed. There was documentation on the completed Medical Emergency Drill Checklists when the drills were not completed. The documentation described the reason the drills were not successful, corrective action taken, i.e., the staff found deficient were either trained "on the spot" and then the drills were repeated, or, if not successful the staffs' supervisors were notified and they were sent to CDT for CPR retraining. • A review of the monthly Safety/Risk Management/Infection Control Committee Meetings minutes, October 2012 through March 2013, showed that the number and results of the drills were reported and any corrective actions taken. The April 2013, Safety/Risk Management/Infection Control Committee Meeting agenda was provided but did not include the minutes of the meeting. The results of the drills were also reported to the Quality Enhancement Department and the Incident	

#	Provision	Assessment of Status	Compliance
		Management Team. For example: On 2/11/13, it was reported there was a choking incident. The report stated the Heimlich Maneuver was successful performed, and the individual was sent to the hospital via emergency medical services for evaluation and treatment. There was no need for corrective action reported because the staff performed the Heimlich Maneuver correctly and successfully. • A review of the required emergency equipment and AEDs found that all required emergency equipment and AEDs were present in the living units. The location of emergency equipment was clearly posted in the living units. The daily Emergency Equipment and AED Checklists were reviewed and showed they were completed for April 2013 and to date for May 2013. • A review of the Monthly Emergency Equipment Walkthrough Checklists Reports provided showed 100% were completed October 2012 through February 2013. No data was available in the document request for review for March 2013 and April 2013. Therefore, the Monitoring Team was unable to determine whether or not the checklists were completed as required or were simply not provided for review. The data provided showed that any problems with the equipment had a work orders submitted or requests for any missing equipment. • There was documentation that 100% of the nursing staff had received competency-based training on the emergency equipment and the Emergency Response Policy. • The Facility reported there were no employees delinquent in Basic Cardio pulmonary Resuscitation (CPR) and CPR for Healthcare Providers training.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	<u>Monitoring Team Findings:</u> The Monitoring Team validated the Nursing Assessment information presented in the Facility's Self-Assessment through: Review of the Nursing Assessment information presented in Provision M.2's Presentation book. Review of documents requested. Conducted meeting/interviews with Chief Nurse Executive, Nursing Operations Officer, QE Nurse, Unit Nurse Manager and numerous staff nurses; observations, and review of medical records. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were not in substantial compliance with Provision M.2 and the Monitoring Team concurs with their findings. <u>Policies, Procedures, Processes, and Protocols:</u> • Since the last compliance review there were no new policies, procedures, and/or processes. • Five new state-wide Nursing Protocol Cards were added to the previously issued 18 Nursing Protocol Cards. The five new Nursing Protocol Cards issued were for: Suspected Fractures/Dislocation, Hypoglycemia, Pain, Emergency/Hospital Transfers, and Fall/Suspected Fall. • DADS Nursing Services Policy, Policy Number: 010.2, was revised on 9/20/12 to	Noncompliance

#	Provision	Assessment of Status	Compliance
		reflect the changes relating to the IRRF and IHCP processes. • RGSC Nursing Services, Standard Operating Procedure NR 400-01, was revised in May 2013, to reflect changes in the DADS Nursing Services Policy and the changes relating to the IRRF and IHCP processes. • Since the last compliance review, the Facility had continued to implement and improve/refine the Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) Processes. From a review of the records the IRRF and IHCP process was continuing to evolve, but was not yet fully implemented, and the Facility was not yet proficient in assessing risk ratings. The IRRF form had been revised to include six clinical risk groups: The effort to group interrelated conditions into six groups was a positive start. However, the interrelationship of conditions does not yet seem to be fully realized. <u>Training Activities:</u> • In October 2012, Integrated Risk ISP/Risk (IRRF and IHCP) process training was provided by the State Office Staff. All RN Case Managers, along with RNs and LVNs attended the training. • Physical Assessment and Documentation Class was provided by the State Office Nurse Practitioner Consultants in December 2012, to all RN Case Managers and RNs. However, the status of RN Case Manager and RN-required RN to RN Check-off and Bedside Check-off completion was not reported in the training documents provided. • All nursing staff were trained on the twenty five state-wide Nursing Protocol Cards. According to the Facility Self-Assessment, the chart below includes the monthly overall percentage of compliance for timeliness and authentication of nursing assessments, August 2012 through January 2013: Month Year / Percentage of Compliance August 2012 / 100% September 2012 / 72% October 2012 / 81% November 2012 / 95% December 2012 / 77% January 2013 / 100% According to the Facility Self-Assessment, the chart below includes the monthly overall percentage of compliance for Annual Nursing Assessment Tool data for September 2012 through November 2012. The overall compliance data for review for December 2012 through April 2013 was not included: Month Year / Percentage of Compliance	

#	Provision	Assessment of Status	Compliance

September 2012	66%
October 2012	78%
November 2012	96%

The lack of overall data for these months may be attributable to the reduction and revision of the 12 original nursing monitoring tools down to six tools, and the revised tools were not yet completed and/or the data not analyzed and reported for these months by the Quality Enhancement Department. The Monitoring Team will follow-up on this issue at the next compliance review.

It was positive to find since the last compliance review, that the Nursing Department had recently hired two additionally RN Case Managers. This gives the Nursing Department a total of four RN Case Managers, which reduces the previous caseloads of individuals' from 30 per RN Case Manager to approximately 15 per RN Case Manager. As the newly hired RN Case Managers mature into their roles and responsibilities, there should be improvement in the timeliness and quality of the nursing assessment going forward to meet compliance with this provision. The RN Case Managers were paired with Qualified Developmental Disability Professionals (QDDPs) who had the same caseloads and were physically located in the same office. This enhanced the ease of communication between the two disciplines. In addition, the RN Case Managers attended and participated at the Morning Medical Meetings; reviewed the 24 Hour Nursing Reports; attended Nursing Shift Reports; and met weekly with the hospital liaison clerk to review appointment schedules to ensure all appointments were kept or missed appointments were rescheduled and kept.

The Monitoring Team requested 10 comprehensive records for offsite review but only nine were received. The most recently completed Admission, Annual, and/or Quarterly Comprehensive Nursing Assessments were selected from both units for individuals with high and/or medium risk ratings, and/or other nursing diagnoses/problems that required nursing interventions. Review was done for Individuals #79, #126, #19, #24, #115, #62, #108, #118, and #72.

Although two new RN Case Managers had recently been hired, the State Office Nurse Practitioner Consultants had provided the mandated Physical Assessment Class, and other State Office staff had provided training on the IRRF and IHCP, no appreciable improvement was found in the content and quality of the nursing assessment since the last compliance review. The review found:

- One of one (100%) Admission Comprehensive Nursing Assessment was completed within 30 days of admission.
- Two of two (100%) Annual Comprehensive Nursing Assessments that were due were completed on time, according to Facility policy.

#	Provision	Assessment of Status	Compliance
		• Two of six (33%) Quarterly Comprehensive Nursing Assessments due were completed on time, according to Facility policy. Of the nine nursing assessments reviewed, five of nine (56%) were completed recently. Four of the nine (44%) were seriously overdue for nursing assessments. They included: • Individual #19 had not had a nursing assessment completed since the Annual Nursing Assessment on 7/23/12. According to the Facility's ISP schedule quarterly nursing assessments were missing for 10/22/12, 1/20/13, and 4/20/12. • Individual #24 had not had a nursing assessment completed since the Admission Nursing Assessment on 6/25/12. According to the Facility's ISP schedule Quarterly Nursing Assessments were missing for 10/21/12, 1/19/13, and 4/19/13. • Individual #72 had not had a nursing assessment completed since the Quarterly Nursing Assessment on 3/10/12. According to the Facility's ISP schedule Quarterly Nursing Assessments were missing for: An Annual Nursing Assessment on 5/3/12, and Quarterly Nursing Assessments for 8/2/12, 11/27/12, and 2/25/13. • Individual #62 had not had a nursing assessment completed since the Quarterly Nursing Assessment on 7/10/12. According to the Facility's ISP schedule quarterly nursing assessments were missing for: Quarterly Nursing Assessments for 10/8/12, 1/6/13, and 3/11/13. The Monitoring Team reviewed nine nursing assessment that were provided for the most recently completed and found four were significantly overdue for two or more quarters. Because four of the above individuals' nursing assessments were significantly overdue the assessments did not contain individuals' current health status, so they were not included in the review. The Monitoring Team reviewed five of the most recently completed nursing assessments using a monitoring tool comparable to the Facility's Annual Nursing Assessment Monitoring Tool. The review found an overall compliance score of 77%. This was comparable to the percentage of compliance found in the Facility Self-Assessment in October 2012, which reported an overall percentage of 78%. These findings, after three years of the Settlement Agreement, demonstrated a substantial lack of compliance with this provision. It is essential the Nursing Department urgently take corrective action to improve the timeliness, content, and quality of nursing assessments. Refer to Provision M.3 and M.5 for information on health care planning.	
M3	Commencing within six months of the Effective Date hereof and with	<u>Monitoring Team Findings:</u> The Monitoring Team validated the Nursing Assessment information presented in the	Noncompliance

#	Provision	Assessment of Status	Compliance
	full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	Facility's Self-Assessment through: Review of the Nursing Assessment information presented in Provision M.3's Presentation book. Reviewed documents requested. Conducted meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, QE Nurse, Unit Nurse Manager, and numerous staff nurses; observations, and review of medical records. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were not in substantial compliance with Provision M.3 and the Monitoring Team concurs with their findings. <u>Policies, Procedures, Processes, and Protocols:</u> • Five new state-wide Nursing Protocol Cards were added to the previously issued 18 Nursing Protocol Cards. The five new Nursing Protocol Cards issued were for: Suspected Fractures/Dislocation, Hypoglycemia, Pain, Emergency/Hospital Transfers, and Fall/Suspected Fall. • Refer to Provision M.2 regarding information on other policies, procedures, and protocols. <u>Training Activities:</u> • Five new state-wide Nursing Protocol Cards were added to the previously issued 18 Nursing Protocol Cards. The five new Nursing Protocol Cards issued were for: Suspected Fractures/Dislocation, Hypoglycemia, Pain, Emergency/Hospital Transfers, and Fall/Suspected Fall. All nurses were reported to have received training on all Nursing Protocol Cards. • In October 2012, Integrated Risk ISP/Risk (IRRF and IHCP) process training was provided by the State Office Staff. All RN Case Managers, along with RNs and LVNs attended the training. • Physical Assessment and Documentation Class was provided by the State Office Nurse Practitioner Consultants in December 2012, to all RN Case Managers and RNs. However, the status of RN Case Manager and RN required RN to RN Check-off and Bedside Check-off completion was not reported in the training documents provided. • All nursing staff were trained on the twenty five state-wide Nursing Protocol Cards. According to the Facility Self-Assessment, IHCPs and Acute Care Plans were individualized for each individual. This was not consistent with the Monitoring Team's findings. Based on the Monitoring Team's review of the Admission, Annual Quarterly Nursing Assessments and Acute Care Plans, no appreciable improvement was found regarding acute or integrated health care plans. The Health Maintenance Plans were no longer used. The Monitoring Team met with the RN Case Managers, NOO, and QE Nurse and discussed the process for developing and implementing Acute Care Plans since the implementation	

#	Provision	Assessment of Status	Compliance
		of the IRRF and IHCP process. There appeared to be some confusion as to when to develop and implement Acute Care Plans. The State Office Nursing Coordinator was contacted for clarification. The clarification provided stated, "If there has been a significant change of status and the team meets, and writes an IHCP, an acute care plan would not be written. Any acute interventions needed for the significant change of status would be written into the IHCP. If the team does not need to meet and does not consider it a significant change of status, such as conjunctivitis, then an acute care plan is implemented within 12 hours by an RN. This acute care plan would then be reviewed by the RN Nurse Case Manager if it has been implemented by another RN on nights or weekends." The Monitoring Team requested a list of five individuals who had recent and/or current Acute Care Plans and Integrated Progress Notes and related documents for acute infections; three individuals were identified. Individual #126 had two recent acute infections, Individual #19 had two recent acute infections, and Individual #40 had one recent acute infection. Review of Individuals' #40, #126, and #19 records found: • Two of three (67%) individuals had Acute Care Plans. Individual #40 reportedly did not need an acute care because of the significant change in status as a result of being hospitalized where he was diagnosed and treated for dehydration and sepsis resulting from a urinary tract infection. Only the Integrated Progress Notes and Physician Orders were provided for review. • Zero of four (0%) Acute Care Plans were identified as whether they were Acute Care Plans or Health Maintenance Plans. • Zero of four (0%) Acute Care Plans contained baseline data that describe what lead up to the necessity for a care plan. • Zero of four (0%) Acute Care Plans had realistic, measurable, and/or observable outcome goals related to the acute problems. • Zero of four (0%) Acute Care Plans were individualized. All were copied directly from stock care plans without any individualization. • Zero of four (0%) Acute Care Plans incorporated relevant nursing protocols, such as Nursing Protocols for: the Antibiotic Therapy, Respiratory Distress/Aspiration, and Urinary Tract Infections, or physician orders that required nursing interventions. • Zero of four (0%) Acute Care Plans included instructions for the direct support professionals. The instruction sheets for direct support professionals stated, "Copy (Acute Care Plan) to be kept in the Individual Record." There were no other instructions on the sheet. The instruction sheets did include the signatures of the Home Managers and direct support professionals. The Monitoring Team's onsite random reviews of individuals' Me Books did not find copies of any health related plans. This issue was identified in previous compliance reviews, with the explanation that the health care plan instruction sheets for direct support	

#	Provision	Assessment of Status	Compliance
		professionals' did not have a record number and could not be placed in the Individual Notebooks. The need to procure record numbers was discussed with the ICF-DD Program and CNE, who gave assurance that record numbers would be procured and the health care plan instruction sheets would be placed in Individual's Notebooks. Additionally, a review of the Facility's Individual Notebooks Audit Tool found that 10 of 10 tools for February 2013 and 10 of 10 tools for March 2013 contained zero health care plan instructions sheets. The need for the direct support professionals to have health care plan instruction sheets in the Me Book was discussed with the CNE, NOO, and QE Nurse. Since the implementation of the IHCP, it is essential that the integrated instructions for the direct support professionals are in the Individual Notebooks and ensure that the respective disciplines provide training to the direct support professionals on their responsibilities related to the health care plans • Zero of four (0%) Integrated Progress Notes included documentation that Acute Care Plans had been initiated and the direct support professionals trained. • Zero of four (0%) Integrated Progress Notes related to nursing assessment and intervention for individuals' acute change in status consistently followed the respective nursing protocols, such as Nursing Protocols for: the Antibiotic Therapy, Respiratory Distress/Aspiration, and Urinary Tract Infections, as required. • Zero of two (0%) Acute Care Plans that should have been resolved had resolution notes in the Integrated Progress Notes or on the Acute Care Plans. It is essential that the RN Case Managers and RNs are retrained on developing and implementing Acute Care Plans and on the Nursing Protocol Cards. Since the last compliance review, the Facility had continued to implement and improve/refine the ISP, Integrated Risk Rating Form (IRRF), and Integrated Health Care Plan (IHCP) Processes. The Facility's Self-Assessment stated that the State Office continued to provide training on the revised IRRF and IHCP Processes. From the Monitoring Team's a review of the records the IRRF and IHCP process was continuing to evolve, but was not yet fully implemented and proficient in assessing risk ratings. The IRRF form had been revised to include six clinical risk groups: The effort to group interrelated conditions into six groups was a positive start. However, the interrelationship of conditions does not yet seem to be fully realized. The Monitoring Team reviewed nine individuals' records for risk ratings and care plans. Individuals: #79, #126, #19, #24, #115, #62, #108, #118, and #72, found: • Five of five (100%) current nursing assessments indicated that of the nursing problems/diagnoses identified for high and/or medium risk ratings and other health conditions that required continuous nursing assessments and interventions had	

#	Provision	Assessment of Status	Compliance
		plans of care. Four of nine (44%) nursing assessments provided for review were not current, one individual's annual assessment was over a year old and three individuals' did not have the last quarterly nursing assessments completed for the past two to three quarters. • Zero of nine (0%) individuals' records had Health Maintenance Plan. All Health Maintenance Plans had been discontinued since the last compliance review. • Seven of eight (87%) individuals' records had risk ratings completed within the current ISP calendar year. Individual #115 who was admitted on 3/18/13 did not have an IRRF completed. Individual #108 did not have a current IRRF; the last risk rating was completed on 1/26/12 on the previously used risk rating form. • Four of eight (50%) individuals' risk ratings completed on the revised IRRF format showed some progressive improvement from the previous format used. None of the four IRRFs (0%) included a summary of risk related diagnoses and conditions that were to be completed by the individual's physician. The substantive content of the clinical data used to determine risk ratings for the six risk groups showed improvement. However, the risk factors within a category and between categories needs more improvement in identifying their interrelatedness when determining risk ratings. • Three of nine (33%) individuals' records had Risk Action Plans. None were completed on the revised IHCP format. Individual #115 who was admitted on 3/18/13 did not have an IHCP completed. Individual #108 did not have a current IHCP; the last risk rating was completed on 1/26/12 on the previously used risk rating form. This was a significant finding which would appear that only three of nine (33%) individuals had a plan of care, or else the plans were not put into their records and/or provided for review as requested. In general, as was found in past reviews, the IRRF and IHCP processes were evolving. As more training is provided and experienced is gained by the IDT and the respective disciplines in developing and implementing these processes, continued improvements will be made in the content of the clinical data and quality of these processes. It is essential that the IDT and respective disciplines consider risk factors within a category and between categories and identify their interrelatedness when determining risk ratings. The Monitoring Team will follow-up on the status and implementation of the IRRF and IHCP processes at the next compliance review.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the	The Monitoring Team validated the Nursing Education information presented in the Facility's Self-Assessment through: Review of the Nursing Education information presented in Provision M.4 Presentation book. Meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, QE Nurse, RN Case Managers, and numerous staff nurses. Observation on the units and review of medical record. Related Self-Assessment	Noncompliance

#	Provision	Assessment of Status	Compliance
	health status of the individuals served.	data were updated while onsite. The Facility's Self-Assessment stated they were not in substantial compliance with Provision M.4 and the Monitoring Team concurs with their findings. <u>Monitoring Team Findings:</u> <u>Policies, Procedures, Processes and Protocols:</u> • Nursing Services Policy was revised in September 2012. • Facility Restraint Policy was updated; no date was included. • Five new statewide Nursing Protocol Cards were issued for: Suspected Fractures/Dislocation, Hypoglycemia, Pain, Emergency/Hospital Transfers, and Fall/Suspected Fall. <u>Nursing Education and Training Activities:</u> As was found in previous compliance reviews, the Nurse Educator did not maintain a centralized Nursing Training database or Information spreadsheet to show the percentage of nurses trained on any particular required topic. Except for some specific training signed rosters, it was not possible for the Monitoring Team to verify the percentage of nurses trained. The Nursing Department had lost two Nurse Educators since the last compliance review. This appears to have hampered the Nursing Department's ability to maintain a consistent system for providing and tracking the status of nursing education. The NOO stated that a RN with a Bachelor's of Science in Nursing (BSN) and a Master's of Science in Nursing (MSN) had been hired as a Nurse Educator and was expected to start to work within the next week. The need for the Nursing Education Department to develop a centralized system for tracking nursing training was discussed with the NOO. Presently, the Nursing Department reported all training to Competency Development and Training (CDT) to record and track. According to entrance Section M Presentation Book and the Facility Self-Assessment the following training was reported: • CDT reported as of March 2013, that 94% of the nurses had received all required training. Copies of each nurses' CDT training records were provided for review, which included all New Nurse/Employee Orientation Training, Annual Competency-based Training, Annual refresher training required by all employees, and other specific nursing training topics. • In February a "block training" push was made, and all RGSC staff was directed to redo all annual trainings. As a result of this effort, in March 2013, a score of 96% compliance was achieved. • Each week the training delinquency report was reviewed, and any nurses with training delinquencies were notified by the Unit Nurse Manager or NOO. Once notified the nurse must complete trainings as soon as possible. All delinquent	

#	Provision	Assessment of Status	Compliance
		trainings must be completed in the month they were identified, or the nurse cannot take any time off. Delinquencies past one month were grounds for corrective action. • The Nurse Educator was utilizing the SSLC Nursing Education Handbook to provide competency-based training. • Statewide Nursing Protocol Cards have been implemented since January 2013. Each nurse has a set of the protocol cards hanging from their name badge. New sets of protocol cards were included with each new nursing name badge issued. Protocol card templates were also available in CWS with a right click in the progress note text box. At the Nursing Meeting, 4/12/12, 22 of 22 floor nurses present (100%) had the protocol cards on their name badge. • The State Office Nurse Practitioner Consultants provided physical Assessment Class in December 2012, to all RN Case Managers and RNs. The status of RN Case Managers and RNs requirement for RN to RN Check-off and Bedside Check-off completion was not reported in the training documents provided. • RN Case Managers, Nurse Educator, and Medical Clinic Nurse November 2012 attended MOSES/DISCUS training at another SSLC. • Clinical Indicators for Common Problems training was provided in New Employee Orientation for all employees. • State Office Staff provided Integrated Risk ISP/Risk (IRRF and IHCP) process training in October 2012. • The State Office Nursing Coordinator provided nursing training in February 2012. The topics covered were not included in the Facility Self-Assessment. • Training was provided on the integrated Medication Administration Policy, 053. • Training was provided on Medication Administration for Individuals with Dysphagia and/or Swallowing Difficulties in April 2013. • Chemotherapy Care training was provided to nursing staff and direct support professionals. • Nursing staff were competency-based trained on Multi-Drug Resistant Organisms (MDRO) Precautions, as well as non-nursing employees. • Other training provided by the Medical Director in the Medical Morning Meetings included: Skin Care, Tardive Dyskinesia, Ostomy Care, Pleural Effusion, and Bruising, <u>Other related training information:</u> • The Nurse Educator reported that a training database had been created and initiated with ongoing improvements being made. However, the Monitoring Team did not find a centralized database in place that listed all of the training topics nurses had received, as well as the overall percentage of nurses trained on each topic, along with a projected date for completion of trained for topics not completed by at least 95%. • The Nursing Department reported that random review of records to ensure Nursing Protocol Card documentation compliance has not been done. Requirements for	

#	Provision	Assessment of Status	Compliance
		following the protocol cards were reinforced at nursing meetings in December 2012, January 2013, and February2013. • The Facility's Self-Assessment stated they had documentation of conducting random interviews with the nursing staff and reviewing documentation in the medical records to validate compliance with the Nursing Protocol Cards. However, this data for validating compliance with all nursing protocols was not provided for review. The Facility's Self-rating stated this provision is not in substantial compliance. Although nursing assessment and reporting protocols were in place that were sufficient to address the health status of the individuals, they have not been in place long enough to meet substantial compliance. By the next visit these items should be implemented long enough, and consistently enough to gain substantial compliance for this M4 item. Based on the Facility Self-Assessment, Section M Presentation Book, documents, and individuals' records reviewed regarding Provision M.4, the Monitoring Team concurs with the Facility's Self-Rating that this Provision was not yet in substantial compliance. However, it was apparent that much training had taken place since the last compliance visit despite the loss of Nurse Educators, although it was not possible to validate the percentage of nurses that were trained on any given topic. It is expected that with the hiring of a competent Nurse Educator and continued training, as well as the continued monitoring by the Nursing Department on nursing assessments, protocols, and documentation, significant progress in moving toward substantial compliance could be achieved in the near future.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	The Monitoring Team validated the Risk Management information presented in the Facility's Self-Assessment through: Review of the Risk Management information presented in Provision M.5's Presentation book. Review of documents requested. Meeting/interviews with Chief Nurse Executive, Nursing Operations Officer, QA Nurse, and Unit Nurse Manager. Attendance at the Pre-ISP Meeting. Review of individuals' medical records. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were in not in substantial compliance with Provision M.5. The Monitoring Team concurs with their findings. Since the last compliance review, the Facility had continued to implement and improve/refine the Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) Processes. The Facility's Self-Assessment stated that the State Office continued to provide training on the revised IRRF and IHCP Processes. From a review of the records the IRRF and IHCP process was continuing to evolve, but was not yet fully implemented and proficient in assessing risk ratings. The IRRF form had been revised to include six clinical risk groups: The effort to group interrelated conditions into six groups was a positive start. However, the interrelationship of conditions does not yet seem to be fully	Noncompliance

#	Provision	Assessment of Status	Compliance
		realized. Policies, Procedures, Processes, and Protocols: Refer to Provision M.2 for policies, procedures, and protocols. Training Activities: • State Office staff provided Integrated Risk ISP/Risk (IRRF and IHCP) process training in October 2012. All RN Case Managers, along with RNs and LVNs attended the training. • The State Office Nurse Practitioner Consultants provided Physical Assessment and Documentation Class in December 2012, to all RN Case Managers and RNs. However, the status of RN Case Manager and RN required RN to RN Check-off and Bedside Check-off completion was not reported in the training documents provided. According to the Facility Self-Assessment, IHCPs and Acute Care Plans were individualized for each individual. This was not consistent with the Monitoring Team's findings. Based on the Monitoring Team's review of the Admission, Annual Quarterly Nursing Assessments and Acute Care Plans, no appreciable improvement was found regarding acute or integrated health care plans. There seemed to be some confusion by the nursing staff regarding when acute care plans were to be developed and implemented. The Health Maintenance Plans were no longer used. The Monitoring Team reviewed nine of the recently Integrated Risk Review Forms and Risk Action Plans for Individuals #55, #98, #101, #114, #5, #66, #47, #11, and #47. • One of nine (11%) identified significant changes in health status since the last review; however, this was difficult to determine based on the available documentation. • Nine of nine (100%) had comprehensive interdisciplinary assessments completed. However, some of the baseline data rationales that supported the risk ratings were more clinically comprehensive than others. Baseline clinical data for Individuals #101, #5, #66, and #47, did not consistently or sufficiently support the risk ratings. The IDT did not include deliberations that lead to the rationale for risk ratings. • Five of nine (56%) assessments provided data that helped identify risk ratings. • Four of nine (44%) risk assessments provided clinical data that helped plan how to address the risk ratings. • One of nine (11%%) had an IHCP completed to address risk ratings. Therefore, from the information attached to the IRRFs it could not be determined whether IHCPs were completed or not from those provided for review. In general, as was found in past reviews, the IRRF and IHCP processes were evolving. As	

#	Provision	Assessment of Status	Compliance
		more training is provided and experience is gained by the IDT and the respective disciplines in developing and implementing these processes, continued improvements will be made in the content of the clinical data and quality of these processes. It is essential that the IDT and respective disciplines consider risk factors within a category and between categories and identify their interrelatedness when determining risk ratings. The Monitoring Team will follow-up on the status and implementation of the IRRF and IHCP processes at the next compliance review. <u>Bowel Tracking and Aspiration Trigger Data:</u> Since the last compliance review, the Bowel Tracking and Aspiration Trigger Databases had been revised and refined to provide daily and retrospective data for both units. In an interview with the ICF-DD Program Director, copies of the data derived from the database were provided for review. She described how the data were used by respective disciplines. It was explained that 63 individuals' (100%), bowel elimination patterns were entered into the database daily by the Direct Support Professionals (DSPs). The clinic clerk daily extrapolated the bowel elimination data and provided the information to the respective unit nurses to monitor. It appeared labor intensive to track and report daily bowel elimination patterns on all 63 individuals. The reliability of the data was questioned as to how one would know that individuals' bowel elimination and aspiration trigger data were reported daily. There did not appear to be a procedure in place for checking the reliability of the bowel elimination and aspiration trigger data. For example, the reliability of the data was further questioned by a statement found in Individual #62's ISPA notes on 4/16/13 by his attending physician regarding the reliability of his bowel tracking data. The physician stated that based on his clinical assessment he did not believe the data and suggested the Facility revisit how they were going to accumulate accurate data. The Monitoring Team's review of 13 Bowel Elimination Monitoring Bar Charts from 2/15/13 to 5/15/13, for Individuals #2, #139, #77, #143, #132, #118, #62, #66, #98, #29, #72, #55, and #79 found: • Four of 13 (44%) charts showed bowel eliminations were recorded from daily to every three days. • Nine of 13 (69%) charts had wide gaps with no bowel eliminations recorded from four to 17 days. Were the days missing for bowel elimination simply not checked, or not record, or did the individuals not have bowel movements? This indicated that the data were grossly unreliable to depend on for tracking individuals' bowel elimination patterns. The QE Nurse explained that the nurses maintained bowel elimination tracking sheets on	

#	Provision	Assessment of Status	Compliance
		the units. He stated he would provide a copy but it was not received. This is a duplication of effort and contributes to further inaccuracy. It is essential that regardless of what method is used to track individuals' bowel elimination patterns, that the Facility have real time and reliable data to use in managing care, particularly for individuals who have high and medium risk rating for constipation/bowel obstructions. The Facility should ensure a process is in place for checking the reliability of the bowel elimination data reported. A review of 17 Aspiration Trigger Data Sheets for May 2013, for Individuals #150, #4, #19, #79, #94, #108, #36, #132, #85, #126, #47, #72, #143, #29, #67, #118, and #97, showed significant improvement since the last compliance review in competing the sheets as required: • Seventeen of 17 (100%) sheets were completed daily on all shifts by the Direct Support Professional. No triggers were identified during the reporting period. • Fourteen of 17 (82%) sheets were initialed daily on all shifts by the nursing staff. • As was found at the last compliance review, the RN Case Managers or other designated RN supervisors did not review the Aspiration Trigger Data Sheet documentation daily as required. It is essential that the RN Case Managers or designated RN supervisors review the documentation on the Aspiration Trigger Data Sheet to ensure they are completed daily on each shift and that any identified triggers are assessed by the nursing staff according to the Aspiration Protocol.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	<u>Monitoring Teams Findings:</u> The Monitoring Team validated the Medication Administration information presented in the Facility's Self-Assessment through: Review of the Medication Administration information presented in Provision M.6's Presentation book and document requests. Meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, QE Nurse, Unit Nurse Manager. Attendance at the Pharmacy and Therapeutics Committee Meeting. Inspections/observations of units' Medication Rooms. Review of Units' Medication Administration Record Notebooks. Conducting Medication Administration Observations. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.6. The Monitoring Team did not concur with their findings. <u>Medication Variance Policies, Procedures and Protocols:</u> • Since the last compliance review, the Facility had implemented the DADS Medication Variance Policy, 053 by attaching it to Pharmacy Policy, Medication Error Report, Standard Operating Procedure PH 100-017-01-09, Date Revised: March 2011. The next projected date for review/revision was March 2012, thus the policy was overdue for annual review.	Noncompliance

#	Provision	Assessment of Status	Compliance
		While the components contained in the Pharmacy Policy, Medication Error Report, Standard Operating Procedure PH 100-017-01-09, were similar, it lacked the specificity contained in the DADS' Medication Variance Policy and Medication Variance Report Form. The Pharmacy policy and reporting form used the outdated term "error" as opposed to the term "Variance." The DADS Medication Variance Policy, 053 had not been operationalized into a Facility policy. The Facility should operationalize the DADS Medication Variance Policy, 053 to ensure consistency and updated terminology. • Another Pharmacy Policy in use was the Administration of Medication, Standard Operating Procedure PH 100-018-01-03 (mm-06.01.011), Date Revised: March 2011. The next projected date for review/revision was March 2012; the policy was overdue for the annual review. <u>Medication Variance Training:</u> • Training was provided on DADS Medication Administration Policy, 053. Training Rosters and CDT Training Records were provided for review but the actual percentage of nurses trained on this policy was not provided. • The Medication Administration for Individuals with Dysphagia and/or Swallowing Difficulties Class was conducted in April 2013. Training Rosters and CDT Training Records were provided for review but the actual percentage of nurses trained this class was not provided. The Facility's Self-Assessment stated more training was scheduled for late April 2013 and May 2013. • Since the last compliance review, a new procedure was implemented to train all staff on change of diet orders, which also affected how medications were prepared and administered. The Monitoring Team reviewed a sample of change of diet orders and accompanying training rosters, September 2012 through April 2013, for Individuals: #94, #60, #29, and #74 and validated that the procedure was in place and found them sufficient to meet individuals' change in dietary orders and instructions for medication administration. <u>Medication Management Workgroup and Pharmacy and Therapeutics Committees:</u> Medication Management Workgroup Committee Meetings<u>:</u> • Five of six (83%) scheduled monthly Medication Management Workgroup Committee Meetings were conducted. There were no committee minutes for November 2012. • The Medication Management Workgroup Committee meetings were combined meetings with the Facility, Mental Health Hospital, and Outpatient Clinic staff. Therefore, it was not possible to accurately evaluate consistent attendance of all core	

#	Provision	Assessment of Status	Compliance
		members for the Facility. • Neither was a team leader/chairperson identified since the contract pharmacist left. The Medication Management Committee should identify a chairperson. • Medication Management Workgroup Committee Meetings consisted of similar topics covered in the Pharmacy and Therapeutic Committee Meeting. Medication Variance analysis and trend data were reported, along with the contributing factors causing the medication variances and corrective actions taken to mitigate the medication variances Because of the Facility's combined meetings with the Mental Health Hospital and Outpatient Clinic there was little devotion paid to the Facility's medication variances regarding critically analyzing, trending, and developing corrective action plans for medication variances, except for the December 2012 committee meeting. The Workgroup Committee did not include data from Medication Administration Observations, Medication Room, and Medication Administration Record Notebook Audits. <u>Pharmacy and Therapeutics Committee Meetings:</u> • There were no copies of the Pharmacy and Therapeutics Committee meeting minutes for the past six months included in the documents requested. • The Monitoring Team attended the Pharmacy and Therapeutic Committee meeting on 5/15/13. The meeting was chaired by Dr. Dill. The 3/27/13, Pharmacy and Therapeutics Committee meeting minutes were reviewed and approved. The QE Nurse presented and provided copies of the medication administration related results of analysis and trend data, 3/1/13 through 5/13/13, for: Medication Management CAP Audit for Floor Stock and Emergency Box Audits, Nursing Care Medication Administration and Documentation Monitoring Tool, MOSES and DISCUS Audits, and Medication Variances., and Medication Variance Investigation Summary Reports. The results of the data for the Medication Management CAP Audit for Floor Stock and Emergency Box Audits, Nursing Care Medication Administration and Documentation Monitoring Tool achieved a compliance score above 90%; therefore no CAPs were required. The contributing factors causing the medication variances and corrective actions taken were described. There was no further discussion by the committee regarding the medication variance data and corrective action plans or follow-up. Data for Medication Administration Observations, Medication Room, and Medication Administration Record Notebook audits were not presented at the committee meetings. The Nursing Department should provide data from Medication Administration Observations, Medication Room, and Medication Administration Record Notebook Audits at the Medication Workgroup Committee and Pharmacy and Therapeutics	

#	Provision	Assessment of Status	Compliance

Committee meetings.

Facility's Medication Variance Data:
The Facility maintained a monthly, quarterly, and longitudinal system for reporting and analyzing medication variances. The medication variances system reported and analyzed data by: Severity Index Categories, day of the week, staff, type, and process node. Data were represented in tabular charts, bar, pie, and line graphs.

The overall data provided for September 2012 through April 2013 showed a significant improvement from previous reviews in analyzing and trending medication variances. A narrative summary accompanied each type of data analyzed and trended. The narrative described the contributing factors causing the variances related to the day of the week, staff involved, and process node (administering, dispensing, and transcribing), as well as corresponding corrective actions taken to mitigate future variances. However, the medication variance data, narratives describing the contributing factors that caused the medication variances and corrective actions taken only included the nursing discipline. There were no reports of medication variances and corrective actions taken for the pharmacy and medical disciplines. In order to comply with medication variance practices all disciplines must report their medication variances and corrective actions taken to mitigate medication variances. The Facility should ensure that all disciplines responsible for medication administration practices report their respective medication variances and corrective actions taken to mitigate the medication variances.

The chart below shows the overall number of medication variances reported year to date, from September 2012 through April 2013:

Medication Variances

Month and Year	El Paisano	La Paloma	Total
September 2012	87	0	87
October 2012	0	1	1
November 2012	0	0	0
December 2012	0	1	1
January 2012	0	4	4
February 2013	1	5	6
March 2013	8	7	15
April 2013	1	3	4
Total	97	21	118

The chart below shows the overall number of medication variances reported by Severity Index Categories and year to date, from September 2012 through April 2013:

Medication Variances by Severity Index Categories*

#	Provision	Assessment of Status	Compliance

Month Year	Category A	Category B	Category C	Category D	Category E	Category F
September 2012	0	0	87	0	0	0
October 2012	1	0	0	0	0	0
November 2012	0	0	0	0	0	0
December 2012	0	1	0	0	0	0
January 2012	3	0	1	0	0	0
February 2013	2	0	4	0	0	0
March 2013	2	0	12	0	0	0
April 2013	2	1	1	0	0	0
Total	10	2	105	0	0	0

* Severity Index Categories defined: Category A: Circumstances or events that have the potential to cause variance. Category B: A variance occurred but the medication did not reach the individuals. Category C: A variance occurred that reached the individual but did not cause harm. Category D: A variance occurred that reached the individual and required monitoring to confirm that it resulted in no harm and/or required intervention to preclude harm. Category E: A variance occurred that may have contributed to or resulted in temporary harm to the individuals and required intervention. Category F: A variance occurred that may have contributed to or resulted in temporary harm to the individual and required initial or prolonged hospitalization.

According to the Facility's analysis summary of the above medication variance data, at the end of April 2013, there were 118 total medication variance reports filed and investigated. Since the reported 87 medication variances in El Paisano for September 2012, a total of 10 variances were reported for that home. Twenty one variances were reported at La Paloma. The current average medication variance was 10.1 per month in El Paloma and 2.6 per month in La Paloma. Taking into consideration the outlier in September 2012 that skewed the average for El Paisano, after eliminating that data, the average for the other seven months was 1.3 per month. The Monitoring Team was told that the 87 medication variances related to orders for one individual being overlooked for approximately three months and each missed dose of medication was counted as a separate medication variance. Although it resulted in a significant increase in medication variances for September 2012, it was positive that the Facility caught the medication variances and correctly reported each as a single event, per policy.

The majority of medication variances occurred on the morning and evening shifts. Most of the medication variances were committed by LVNs, for whom medication administration was their primary job responsibility. Two medications variances were committed by RNs, of which one variance was due to failure to identify the individual and the other was due to the illegibility of the medication written on the Medication Administration Record. Other factors contributing to medication variances included high volume use of contract nurses, which impacted continuity of care; distractions; and

#	Provision	Assessment of Status	Compliance
		nurses' failure to consistently follow the "six rights" for medication administration. Corrective actions were taken, which included completion of medication administration tests, medication administration observations, and counseling by their respective supervisor. <u>Facility's Medication Administration Observation Data:</u> In addition to the medication administration data presented and provided at the Pharmacy and Therapeutics Committee meeting on 5/1/13, Medication Administration Observation data for September 2012 through April 2013 was provided for review. The data showed that quarterly Medication Administration Observations were completed by the Unit Nurse Manager and the NOO. The overall percentage compliance scores were above 90% for both oral and enteral medication administration. Because compliance scores of 90% or greater were achieved, the Facility's Self-Assessment reported there were no systemic CAPs required. At the time of the Medication Administration Observations, on the spot training was provided for any nurse whose compliance score fell below 90% compliance. In January 2013 the Facility implemented and began using the revised State Medication Administration Observation form, which identified items on the form that were "Essential Elements" and must be met 100% of the time; failure to meet these criteria required, "immediate retraining (on medication administration practices): a total score of less than 90%, or any missed Essential Elements." For example, a review of the completed Medication Administration Observations for the time period reported showed that on 3/19/13, one nurse's Medication Administration Observation had a score of 69% compliance. There was documentation that the nurse received retraining and follow-up observation. The Medication Administration Observation data should be presented and reviewed, at the Medication Workgroup Committee and Pharmacy and Therapeutics Committee meetings, and further corrective action taken when indicated. <u>Monitoring Team's Review of 10 Most Recently Completed Medication Variances:</u> While on site the Monitoring team requested and received 10 of the most recently completed Medication Variance Reports for Individuals #2, #82, #94, #98, #118, #91,#149, and #15 (Individual # 15 had three Medication Variance Reports). Findings included: • Ten of ten (100%) Medication Variance Reports were completed for all applicable items on the report form A through N. Seven of the 10 (70%) medication variances were committed by nurses, two (20%) variances were committed by pharmacy technicians, and one (10%) variances was committed by a physician. • Ten of ten (100%) Medication Variance and Investigation Reports included documentation that the disciplines responsible for committing the variance had	

#	Provision	Assessment of Status	Compliance
		corrective action taken by their respective supervisors upon discovery. • Ten of ten (100%) medication variances were thoroughly investigated by the RN Supervisor who was responsible for conducting Medication Variance Investigations. All Medication Investigation Reports had supporting documentation attached for conducting the investigations. • Nine of ten (90%) Medication Investigation Reports were completed and entered into CWS within five working days, per Facility policy. One medication variance investigation was 12 days late. In reviewing the April 2013 Medication Variance Reports a discrepancy was found between the numbers of medication variances reported. There were five Medication Variance Reports reviewed for April 2013 but only four were reported in the above tabulation for April 2013. It is essential that all Medication Variance Reports are entered for the monthly reports. Otherwise, the data are skewed or the medication variances are not reported. As was mentioned in previous compliance reviews, after reviewing the continued low incidents of medication variances reported and the Monitoring Team's review of Medication Administration Record, the concern remained regarding under-reporting. For example: • Review of Medication Administration Records for Individuals # 79, #126, #19, #24, #115, #62, #108, #118, and #72, for the period of 4/1/13 through 5/13/13 found: o Eight of nine (89%) individuals' Medication Administration Records reviewed were not initialed as given or circled with an explanation for the omission for documentation for a combined total of 240 doses of medication; this would make it appear that these doses of medication were not administered. o Individual #19 had a total of 38 doses of medications not initialed, which is of particular concern because the prescribed combined seizure medications (Phenobarbital, Valproic Acid, Dilantin, and Keppra) were not initialed as given for 17 of 38 (45%) doses: ▪ Phenobarbital was not initialed on: 4/15/13 at 0400, 4/22/13 at 0400, 4/26/13 at 2000, 5/3/13 at 2000, 5/9/13 at 1200, and 5/11/13 at 2000. ▪ Dilantin was not initialed on: 4/15/13 at 2000, 4/26/13 at 2000, and 5/3/13 at 2000. ▪ Valproic Acid was not initialed on: 4/22/13 at 1600, 4/26/13 at 2000, 4/28/13 at 1600, 5/3/13 at 1600, 5/3/13 at 2000, and 5/11/13 at 1600. ▪ Keppra was not initialed on: 4/26/13 at 2300 and 5/3/13 at 2000. o Individual #19 had seizure activity reported on: 4/23/13 at 12:38 p.m., 4/30/13 at 6:43 p.m., 5/4/13 at 10:45 a.m., 5/4/13 at 3:10 p.m., 5/5/13	

#	Provision	Assessment of Status	Compliance
		2:20 p.m., 5/5/13 at 5:50 p.m., 5/6/13 at 6:51 p.m., 5/9/13 at 1:13 p.m., 5/9/13 at 8:33 p.m., and 5/11/13 at 11:55 a.m. It is plausible to question if the seizure medication that were not initialed were omitted and contributed to breakthrough seizure activity. The Monitoring Team was aware of past practices of initialing medications administered on both the MediMar and on paper MARs. For the individuals' MARs identified above, the Unit Nurse Manager or designee should crosscheck the paper MARS against the MediMar that was used during the timeframe above to reconcile the two systems for documenting medications administered. For any medications that are not reconciled, a Medication Variance Report should be completed. If the MediMar system was not used during this timeframe, all of the medications that were not initialed on the paper MAR should be considered a medication variance and Medication Variance Reports completed on medications not initialed. This points out the critical need for the Unit Nurse Manager or designee to conduct Medication Administration Record (MAR) audits on <u>all</u> MARs at least weekly or more often until this problem is resolved. The Facility should evaluate the possibility of under-reporting medication variances and take corrective action to ensure that all medication variances are reported according to DADS Medication Variance Policy, 053. <u>Monitoring Team's Inspections/Observations of: Medication Rooms, Medication and Administration Record Notebook, Narcotic/Control Drug Log, and Glucometer Logs:</u> The Monitoring Team, accompanied by the CNE, NOO, QE Nurse, Unit Nurse Manager, and Nursing Supervisor, inspection/observation of La Paloma's medication room found: • Although the space in the medication room was very small the room and medication carts, medication refrigerators were clean and free from undue clutter. The biohazard waste container was not overly full. • The Facility had obtained a much needed new medication refrigerator; temperatures for May 2013 were check and recorded daily. There were no food stuffs or personal items in the medication refrigerator. The refrigerator for individuals' food stuffs used for medication administration and other individual related items contained no personal food stuffs. There were no opened containers of food stuffs in individuals' refrigerator. • Required signs for Do Not Crush List, Sound Alike/Look Alike Poster, High Risk/High Alert Poster, and Poison Control Poster were visibly posted on the bulletin board in front of the medication cart. • Open bottles/vials were labeled with "Do Not Use Beyond" dates and initialed by the nurse who opened. There were no expired medications found. Oral and topical	

#	Provision	Assessment of Status	Compliance
		medications were separated in the medication cart and in storage areas. • Liquid medications were being supplied in unit doses where available. The individuals' unit doses of liquid medication required a great deal of space for storage. Each individual's liquid unit dose medications were put in a plastic storage container and stored on an open shelf on the medication room wall and were not in a locked cabinet. This appeared to be a security issue because the medications were not behind double locks and needed to be addressed by the Pharmacy. The QE Nurse and Unit Nurse Manager agreed this should be done and stated they would follow-up with the Pharmacy. Further, it was observed that one individual had liquid unit doses of Valproic Acid and Milk of Magnesia loosely mixed together in the same plastic container. The QE Nurse and Unit Nurse Manager agreed to address this with the Pharmacy. • A black tackle box was used to store discontinued and/or medications to be returned to the Pharmacy. The nursing staff stated that the Pharmacy picks up the returned medications daily. The box had no security lock. Inspection of the box found a plastic bag with medications for return without a return to pharmacy form identifying who the medication belongs to, the reason for the return, date, and the nurse's name. Completing return slips for medications returned to the Pharmacy is essential to reconciling medications to ensure the reasons medications are returned were explained. Medications that cannot be reconciled amount to medication variances and result in under reporting. The nursing staff stated they would immediately fill out a return to the pharmacy form for the medication in the box. The QE Nurse and/or Unit Nurse Manager agreed to address the security of tackle box used for returned medications with the Pharmacy. • The Emergency Box contained an outside list of required medications and was locked with a breakaway lock. • A recently added locked storage container was mounted to the wall to dispose of all expired medications, for which only the Pharmacy had a key for security purpose. • The Narcotic/Control Drug Log and drugs were changed out daily by the Pharmacy. The narcotic/control drugs were kept in a separate double locked container in the medication cart. The narcotic/control drugs were counted against the Narcotic/Control Drug Log. The count was off by one medication;the log said 51 when there were 50. The staff nurse stated he had not signed out for the morning medication administered. The error was corrected on the spot. The Pharmacy had replaced Narcotic/Control Drug Log from the previous day and replaced it with a new sheet. There were double signatures for the pharmacy personnel and the nurse receiving the medications that morning. Since there had been no change in shift at the time of the inspection there was no need for double nursing signatures until the change of shift. • The Medication Administration Record Notebook was reviewed and found that the	

#	Provision	Assessment of Status	Compliance
		Universal Signature Sheet had not been updated. Many staff had come and gone since it was put in place. Most of the signatures and initials were illegible and many were written below the line on the page. The Unit Nurse Manager immediately replaced the signature sheets in both units and will update the signatures of all nurses presently administering medications in both units. Individuals' Medication Records contained current PNMPs. It was positive to find since the last review that the PNMTs also contained individuals' pictures and pictures of required adaptive equipment needed for medication administration, when indicated. • The Glucometer Notebook was reviewed and found all glucometer testing was completed as required. The testing solutions were within date. Glucometer testing solutions were routinely changed every 30 days. The Monitoring Team, accompanied by the CNE, NOO, QE Nurse, Unit Nurse Manager, and Nursing Supervisor, inspection/observation of El Paisano's medication room found: • At the time of the medication room inspection/observation two pharmacy technicians and the floor nurse were conducting medication cart exchanges/refills. The process was observed; a new process for cart exchange was started two weeks ago. The pharmacy brought a list of each individual's medications. As medications were refilled the pharmacy technician and the nurse crosschecked each individual's medication by counting the number of medications for each individual against the pharmacy list. Any discrepancies were corrected on the spot. Medication expiration dates were checked, any expired medications were returned to the pharmacy. This process ensured that the pharmacy brought the correct medication and the correct supply needed. This appeared to be an efficient and effective process to ensure the accuracy of the cart exchange. No further inspection of the medication room was conducted so as not to interfere with the cart exchange process. <u>Monitoring Team's Medication Administration Observations for Oral and Enteral Medications:</u> Medication Administration Observations were conducted in La Paloma on 5/14/13 at the 4:00 p.m. med pass, accompanied by the QE Nurse found: • The nurse administering medications followed current generally accepted standards of safe medication administration practices except: o At the beginning of the med pass the nurse was not consistently telling individuals what medications they were about to receive or the purpose of the medications. The QE Nurse provided prompting to the nurse to correct this issue and the nurse immediately complied throughout the remainder of the med pass. o The nurse started to document the medications before they were administered. The nurse was prompted to not document the medications	

#	Provision	Assessment of Status	Compliance
		until they were administered. The nurse immediately complied. o The nurse was prompted to retain the open medication package on the cart before disposal to use for the third required check when documenting the administration on the Medication Administration Records. o During the med pass the nurse did not informally implement individuals' who had Self-Administration of Medication Programs. The formal Self-Administration of Medication programming for individuals was scheduled for on Mondays. Otherwise, informal programming was to take place at each med pass. • The direct support professional assisted the nurse during the med pass by bringing one individual at a time to the Dutch door to receive medication. Because medications were administered through a Dutch Door with a small enclosed alcove, at best, it was difficult to prevent other individuals from coming to the door during med pass. It was difficult to maintain strict privacy in this environment. • A different nurse (RN) was observed administering enteral nutrition to Individuals #79 and #47. The RN's performance of administering enteral nutrition was exemplary. All current and generally accepted standards of practice for safe administration of enteral nutrition were precisely followed. Individuals were provided privacy either in their bedroom or in the treatment room. The nursed treated the individuals with dignity and respect. A review of Individuals #79 and #47s' Enteral Feeding Records for 5/1/13 through 5/13/13, found that not all orders were initialed consistently daily on all shifts. If the orders were not carried out for some reason the block on the records should be circled and an explanation documented in the Integrated Progress notes or on the back of the records why the orders were not carried out. Leaving blanks on the records makes it appear that the orders were not carried out. The Nursing Department should ensure that all enteral feeding orders included on individuals' Enteral Feeding Records are consistently carried out as ordered and documented. Medication Administration Observations were conducted in El Paisano on 5/15/13 at the 4:00 p.m. med pass, accompanied by the QE Nurse found: • The nurse administering medications followed current generally accepted standards of safe medication administration practices except: o The nurse told individuals the names of their medications but did not consistently tell them the purpose of the medications. The QE Nurse prompted the nurse to include the purpose of the medications they were receiving. The nurse immediately complied throughout the remainder of the med pass. o The nurse was prompted to retain the open medication package on the cart	

#	Provision	Assessment of Status	Compliance
		before disposal to use for the third required check when the documenting the administration of the Medication Administration Records. o The nurse broke a calcium pill with bare fingers as oppose to using the pill cutter. This was discussed with the QE Nurse and CNE who will take corrective action with the nurse. • Individual #140 hyperextended her head and neck when drinking fluids after taking medication. Afterwards she had a slight cough. A copy of the Integrated Progress Note documented evidenced that floor nurse immediately completed a focus assessment according to the Aspiration Protocol. Assessment findings were within baseline. A review of Individual #140's PNMP did not identify hyperextension of the head and neck as a risk. However, the position plan for medication administration stated, "Positioned upright, cue her to stand up straight, and ensure all medications are swallowed." The nursing staff were advised to follow-up with the PNMT regarding hypertension of the head and neck when drinking fluids. Individual #140 was prescribed Lisinopril 20 mg daily at 7:00 a.m., with instructions to hold the medication if systolic blood pressure was less that 110mm/hg. The Vital Signs records did not show documentation that the blood pressure was taken on 5/5/13, 5/6/13, and 5/7/13 but the remainder of the month to date of the review they were taken daily. • The nurse and direct support professionals treated individuals with dignity and respect. • The direct support professional assisted the nurse during the med pass by bringing one individual at a time to the Dutch door to receive medication. Because medications were administered through a Dutch Door with a small enclosed alcove, at best, it was difficult to prevent other individuals from coming to the door during med pass. It was difficult to maintain strict privacy in this environment. • The nurse valiantly attempted to provide informal training for individuals with Self-Administration of Medication Programs. However, this was a heavy med pass with at least 31 individuals receiving medications; this coupled with the physical environment made it extremely difficult to have sufficient time and atmosphere to effectively provide even informal Self-Administration of Medication training, much less to provide the formal training. General issues identified in both El Paisano and La Paloma: • Four of five (80%) Self-Administration of Medication Program records for individuals with programs had the required weekly training documented. The nurse staff were responsible for formally implementing and documenting Self-Administration of Medication Programs weekly and providing informal training at each med pass. The Nursing Department should ensure nurses administering medication consistently implement and document individuals' Self-Administration of	

#	Provision	Assessment of Status	Compliance
		Medication Programs as designed. • As reported in previous compliance reviews, the environment for administration does not allow for adequate privacy for medication administration or freedom of distractions for the nurse while administering medication. The morning and evening med passes included giving medication to at least 30 plus individuals. All of these factors have the potential to contribute to medication variances, as was reported in the medication variance data. It was difficult for the nursing staff to have time to pass medications to 30 plus individuals within the required time frame. In addition, the heavy med passes and the physical environment were not conductive for the nursing staff to adequately implement individuals' Self-Administration of Medication Programs. The NOO stated that a work order had been submitted to create two rooms in both units, a room on each end of the halls, to provide medication administration. By having two rooms dedicated for medication administration the number of individuals receiving medications, particularly at the morning and evening med passes, will be reduced to approximately 15 individuals, which will allow time to pass medications within the required time frame, reduce distractions and help avoid medication variances, as well as allowing for more time to provide Self-Administration of Medication training. The Monitoring Team supports the need to have two medication rooms in both units. Although the Monitoring Team found that significant progress was made in this Provision throughout the onsite review and review of documents, the Facility had not yet consistently achieved substantial compliance in all aspects of medication administration practices. Areas that notably need continued improvement include: medication variances were not specifically reported for the medical and pharmacy disciplines. The Medication Workgroup Committee and Pharmacy and Therapeutics Committee should complete a more in depth analysis of factors contributing to the variances and re-evaluate/strengthen strategies used for corrective action, particularly those variances that continue to be repeated, e.g., variances made by nurses and pharmacy technicians due to distractions and those made by agency nurses. The Nursing Department should: Enhance oversight of nurses' administration of medication practices to ensure compliance with current and generally accepted standards of safe medication administration practices and enhance Medication Room, and Medication Administration Records and Treatment Notebook audits. The Facility should urgently consider the work order request for converting both units' two rooms on each end of the hall for medication rooms.	

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

1. The Nursing Department should ensure that all Nursing Care Monitoring Tools and Protocol Card Audits 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)

2. The Quality Enhancement Department needs to enhance inter-rater reliability checks on all nursing monitoring and audit tools, as well as Medication Observations. (Provision M.1)
3. The Infection Control Policies should be review and those that are overdue for annual review/revision and should be updated. (Provision M.1)
4. The Infection Control Preventionist should provide technical assistance to the nursing staff by reviewing their Acute Care Plans for infections to ensure they include preventative measures, assist the nursing staff put preventative measures in place, and provide staff training to prevent the spread of infectious and communicable disease. (Provision M.1)
5. The Skin Integrity Committee should develop and implement a monthly and longitudinal tracking system for all stages of pressure ulcers, using an approved tool such as use the Pressure Ulcer Scale for Healing (PUSH) method for assessing pressure ulcers or SSLC Wound Assessment Progress Report. (Provision M.1)
6. The Nursing Department should urgently take corrective action to improve the timeliness, content, and quality of nursing assessments. (Provision M.2)
7. The Facility should ensure that DSP Instruction Sheets for the direct support professionals are put in the Individual Notebooks (which may require assigning them record numbers), as well as ensuring that the respective disciplines provide training to the direct support professionals on their responsibilities related to the integrated health care plans. (Provision M.3)
8. The Nursing Department should ensure the RN Case Managers and RNs are retrained on developing and implementing Acute Care Plans and on the Nursing Protocol Cards. (Provision M.3)
9. The Nursing Department should ensure that the RN Case Managers or designated RN supervisors review the documentation on the Aspiration Trigger Data Sheet to ensure they are completed daily on each shift and that any identified triggers are assessed by the nursing staff according to the Aspiration Protocol. (Provision M.5)
10. The Nursing Department should ensure that all enteral feeding orders included on individuals' Enteral Feeding Records are consistently carried out as ordered and documented. (Provision M.6)
11. The Nursing Department should present data from Medication Administration Observations, Medication Room Audits, and Medication Administration Record Notebook Audits at the Medication Workgroup Committee and Pharmacy and Therapeutics Committee meetings. (Provision M.6)
12. The Nursing Department should: (Provision M.6)
    a. Enhance oversight of nurses' administration of medication practices to ensure compliance with current and generally accepted standards of safe medication administration practices.
    b. Enhance Medication Room, and Medication Administration Records and Treatment Notebook Audits.
13. The Facility should evaluate the possibility of under reporting medication variances and take corrective action to ensure that all medication variances are reported according to DADS Medication Variance Policy, 053. (Provision M.6)

The following are offered as additional suggestions to the Facility:

1. The Facility should ensure that the IDTs and respective disciplines consider risk factors within a category and between categories and identify their interrelatedness when determining risk ratings. (Provision M.5)
2. The Facility should ensure that a process is in place for checking the reliability of the bowel elimination data reported. (Provision M.5)
3. The Facility should operationalize the DADS Medication Variance Policy, 053 to ensure consistency and updated terminology. (Provision M.6)
4. The Facility should ensure that the Medication Workgroup Committee and Pharmacy and Therapeutics Committee should complete a more in depth analysis of factors contributing to the variances and re-evaluate/strengthen strategies used for corrective action, particularly those variances that continue to be repeated, i.e., variances made by nurses and pharmacy technicians due to distractions and those made by agency nurses. (Provision M.6)

5. The Facility should urgently consider the work order request for converting both units' two rooms on each end of the hall for medication rooms.

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Self Assessment 4/29/2013 2. RGSC Action Plan 4/25/2013 3. RGSC Presentation Book, 5/2013 4. RGSC Policy: Standard Operating Procedure NR 200-66: Medication Error Policy, revised 12/2007 5. Medication variance data for 12/2012 through 4/2013 6. Medication management workgroup notes for 11/20/2012; 12/18/2012; 1/29/2013; 2/19/2013; and 4/1/2013 7. Drug utilization evaluation (DUE) materials for DUEs developed during the reporting period: Clozaril, and Geodon 8. P&TC meeting minutes, 12/19/2012 9. Completed adverse drug reaction (ADR) report form for Individual #6 10. Provision J.12 report findings from this report 11. List of all individuals on an antipsychotic, and had a diagnosis of diabetes, and/or hypertension, and/or hyperlipidemia; along with the most recent QDRRs for the last ten individuals on the list 12. List of individuals who were prescribed polypharmacy 13. List of individuals who were prescribed anticholinergics 14. List of individuals who were administered a stat chemical restraint for a behavioral exacerbation during the reporting period 15. Data tables that were dated 9/12 through 4/13 with information on use of anticholinergics and benzodiazepines 16. Quarterly Drug Regimen Reviews (QDRRs) for Individuals #82, #3, #55, #8, #132, #15, #93, #62, #87, #19, #47, #134, #91, #60 17. Copies of the last 15 new prescription orders written (Individuals #126, #82, #139 (two scripts), #12, #145, #50, #59, #115 (two scripts), #119, #86 #63, #19, and #98) 18. Copies of the first ten single patient drug interventions (SPDIs) that occurred in February 2013 **People Interviewed:** 1. Anne Ikponmwonba, RPh (director of pharmacy) 2. David Moron, MD (Clinical Director) 3. Maria Dill, MD (Medical Director) 4. Gary Sauceta (Information Technologist) **Meeting Attended/Observations:** 1. P&TC subcommittee, medication management workgroup, 5/15/2013 2. Polypharmacy meeting, 5/13/2013
	Facility Self-Assessment: For Provision N.1, the self-assessment did not address physician review and follow-up to pharmacy recommendations, and did not define specific criteria for substantial compliance.

	For Provision N.2, the self-assessment did not assess if anticholinergics, polypharmacy, benzodiazepines, and stat chemical restraints were reviewed, assessed, and specific recommendations to reduce the use of these drugs, when clinically indicated. Also timeliness of QDRR completion was not assessed. QDRRs must be completed quarterly. For Provision N.3, the self assessment did not assess a systems review for anticholinergics, benzodiazepines, polypharmacy, and stat medications for psychotropic indications. The assessment also did not ensure that these issues were appropriately addressed in the QDRRs Provision N,4 self-assessment did not assess SPDI reports, as the physician must review and follow-up on recommendations made for each SPDI. Based on the results of the assessment, the Monitoring Team could not understand the rationale for noncompliance, as criteria rating for compliance was not identified. Provision N.5 self assessment did not assess if MOSES and DISCUS were completed more timely, as clinically indicated and there was not criteria rating listed for compliance. Provision N.6 self assessment did not fully assess the ADR process, including training for ADRs, completion of the forms, trends analysis of ADRs, and reporting practices to the FDA, when necessary Provision N.7 self assessment did not assess if pre-determined DUEs were selected for the year, if DUEs were developed for FDA and manufacturers advisories, and warnings, and if clinically relevant recommendations were made by the pharmacists, and followed up one, and if there was a comprehensive review of the DUE at the P&TC meeting. For Provision N.8, the entire self assessment must be revised to reflect the new medication variance process, including training, reporting, data analysis, documenting, development of action plans, and P&TC review of medication variances.
	Summary of Monitor's Assessment: The Monitoring Team noted improvement in pharmacy services, and finds substantial compliance with Provision N.4. The Facility had enhanced its QDRR process, developed a polypharmacy committee and medication management workgroup, improved data collection on medication variances, and is ensuring physician review and follow-up on pharmacy recommendations. The following are specific comments for each of the Provisions: Provision N1: The Monitoring Team noted that the pharmacy department had documented an appropriate review of new medication orders, and ensured that necessary diagnostics were obtained when needed; however, by review of the documents provided, there was a significant delay in many cases between when the medication was ordered, and when the script was reviewed by the pharmacists. For this reason, the Monitoring Team determined that the Facility was not in compliance with Provision N.1, and must enhance its process by ensuring a prompt review of all new medication orders. The Monitoring Team would like to

	point out that the Pharmacist provided excellent clinical recommendations, and follow-up for Individual #59. Provision N2: The Monitoring Team noted significant improvement with the comprehensiveness of pharmacy completion of the QDRRs, and review and follow-up by physicians. The Monitoring Team noted that the QDRR summaries were not organized in any specific way, and the Monitoring Team strongly recommends that the pharmacist document all relevant components of the QDRR in sections (for example, a section for laboratory review, and sections for metabolic risk factors, benzodiazepines, anticholinergics, polypharmacy, etc.). Because the pharmacy was significantly behind with completing QDRRs timely, the Monitoring Team determined that the Facility was not in compliance with N2, of the Settlement Agreement. Provision N3: The Monitoring Team has noted many improvements in developing and implementing action plans towards compliance with Provision N.3. For example, the new polypharmacy committee will help reduce the use of polypharmacy; the Facility had improved collecting data on the use of stat medications and improved on assessment of metabolic syndrome. Substantial compliance will require continued improvement by develop enhanced systems to review each of these issues. The Facility must also ensure that the QDRR process provides a specific and comprehensive review of the use of polypharmacy, anticholinergics, benzodiazepines, stat chemical restraint for psychiatric indications, and metabolic syndrome. Provision N4: The Monitoring Team was most impressed with the pharmacy's process for assessing, documenting, and reporting of SPDIs. The pharmacists ensured precise documentation of the issue, ensured that the prescribing physician was notified of the issue, and followed up through resolution, ensuring that the issue was appropriately managed. The Monitoring Team noted that the prescribing physician appropriately managed recommendations made through the QDRR process. The Monitoring Team congratulates the pharmacist and prescribing physicians for developing and implementing a process that has resulted in substantial compliance for Provision N.4. Provision N5: The Monitoring Team compliments the Facility for enhancing its monitoring of side effects of individuals who were prescribed neuroleptic medication. The Monitoring Team noted that all six individuals were provided enhanced monitoring by means of both the DISCUS and MOSES assessments, following a dose increase of a neuroleptic. Also, the Facility ensured that MOSES and DISCUS assessments were completed routinely, and assessment forms were reviewed and signed by the prescriber within seven days from the date of the assessment. Provision N6: The Monitoring Team determined noncompliance for Provision N6, and strongly encourages the Facility to develop and implement a robust ADR process, by enhancing the ADR reporting form; ensuring that all relevant staff are trained on identifying and reporting of ADRs (including physicians, pharmacy staff, nurses, direct care staff, and others who are regularly in contact with individuals); ensuring that the reporting forms are completed in full and accurately; ensuring that FDA reportable ADRs are reported to the FDA immediately; and conducting regular review of ADR data, and trends analysis.

	Provision N7: The Monitoring Team determined that the Facility remained not in compliance with Provision N7. Substantial Compliance will require the Facility to enhance its current DUE process by ensuring that DUE selection, of at least one drug or drug category be selected for by the P&TC committee for each quarter during the year. In addition, the Facility must implement a DUE for all FDA advisories, and manufacturers warnings. A schedule must be maintained that tracks all delivered and pending DUEs, as well as follow-up on DUE-initiated action plans. Action plans must be developed, implemented, and tracked for each DUE, as clinically necessary. A DUE must include assessment of the drug by assessing monitoring parameters, such as laboratory data, include a summary of all relevant clinical issues, provide recommendations for the prescriber, and a process to ensure that recommendations are completed, and affective. The P&TC should review all DUEs and ensure that recommendations are clinically appropriate, and that the Facility adheres to recommendations. Provision N8: The Monitoring Team was impressed with the efforts to develop a functional medication variance process. A new workgroup, called the medication management workgroup, has been meeting monthly and is focusing on developing the infrastructure for the Facility's medication variance process. Medication variance data was being collected, and categorized on a monthly basis. Members of the workgroup should be recognized for the efforts in moving forward towards compliance with Provision N.8. At the time of this review, the Monitoring Team determined that the Facility continued noncompliance with Provision N.8, and strongly encourages the Facility to move assertively to implement a robust medication variance process. The Facility must ensure medication variances are differentiated by discipline, such as nursing, pharmacy, and physician services; there must be a robust trends analysis completed for the data monthly, and summarized quarterly; a process for staff remediation, and when necessary, administrative action, must be developed; action plans and follow-up to action plans must be developed for all relevant variances; the P&TC committee must review all medication variance data, analysis, and action plans, follow-up to actions plans, remediation, administrative actions, and provide comments and recommendations for the medication variance workgroup. The medication variance workgroup, should identify a chairperson, and ensure that department leadership for nursing, pharmacy, and physician services attend each meeting of the workgroup. The medication variance policy must be updated to reflect the Facility's current practice.

#	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	To assess if the pharmacist conducted a review of each new medication order, the Monitoring Team requested that from the last 15 new prescription orders (Individuals #126, #82, #139 (two scripts), #12, #145, #50, #59, #115 (two scripts), #119, #86 #63, #19, and #98), and documentation to demonstrate a pharmacist's review, and all supporting evidence. Of the fifteen scripts reviewed: • Fifteen out of 15 (100%) demonstrated a review of allergies, side effects, contraindications, appropriateness of the medication, and dosing.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• Of the five scripts that required laboratory monitoring, five out of five (100%) indicated that laboratory monitoring was either ordered, or demonstrated that it had been completed. • In 15 out of 15 cases (100%), the primary care provider, and when clinically indicated, the psychiatrist, documented acceptance or rejection of the pharmacist's recommendations o In those cases that were rejected, there was clinically justifiable rationale, with an associated action plan, documented by the appropriate physician. The Monitoring Team noted significant concerns upon review of two cases (#63, and #19): • Individual #63 had an order on 5/3/2013 to discontinue warfarin 2.5 mg and start 3.0 mg of warfarin. The Monitoring Team noted on the medication list that the 2.5 mg warfarin dose had been discontinued on 4/22/2013 at the same time that warfarin 3.0 mg was ordered. There was no corrective action noted for this discrepancy at the time of the 5/3/2013 order. • For Individual #19, there was an order written for an antibiotic for a UTI; however, the medication was not listed on the medication list provided to the Monitoring Team. The Monitoring Team also noted a significant delay between the actual order and dispensing date, and when the pharmacists documented review occurred. For example: • A script for Kayexalate was written on 4/23/2012 for Individual #40, but the pharmacy review was not until 5/6/2013. • A script for Prolia was written on 4/29 for Individual #59, and the documented review was on 5/7. • An antibiotic for a UTI was written on 5/4/2013, for Individual #19; however, the pharmacist did not review until 5/10. <u>Summary</u>: The Monitoring Team noted that the pharmacy department had documented an appropriate review of new medication orders, and ensured that necessary diagnostics were obtained when needed; however, by review of the documents provided, there was a significant delay in many cases between when the medication was ordered, and when the script was reviewed by the pharmacist (following the compliance visit, the Facility stated that the Monitoring Team did not request verification time from the CWS and WORx systems, and that pharmacist review and verification of physician's orders is done on the CWS and WORx systems within 24 hours). For this reason, the Monitoring Team determined that the Facility was not in compliance with Provision N.1, and must enhance its process by ensuring a prompt review of all new medication orders. The Monitoring	

#	Provision	Assessment of Status	Compliance
		Team would like to point out that the Pharmacist provided excellent clinical recommendations, and follow-up for Individual #59.	
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 that the pharmacy department conducts a comprehensive quarterly drug regimen review, that is consistent with standard of care practice, the Monitoring Team reviewed the first five QDRRs completed for February, March and April, of 2013 (Individuals #82, #3, #55, #8, #132, #15, #93, #62, #87, #19, #47, #134, #91, #60). Specific documents reviewed were the past two QDRRs and associated QDRR worksheets, last six months labs, and EKGs, and medication list. Findings were that: • Of the 15 cases reviewed, two out of 14 (14%) demonstrated that QDRRs were reviewed at least quarterly. • 15 out of 15 (100%) indicated a comprehensive review of all necessary diagnostic results, such as laboratory, and EKGs, as necessary. • 15 out of 15 (100%) indicated review, and documented appropriate follow-up action by the prescribing physician. • Of the four samples that required the psychiatrist to review the QDRR, four out of four (100%) indicated review by the psychiatrist. • In the zero out of one (0%) observed case that included the prescribing of an anticholinergic medication (Individual #134), the pharmacist did not document a s specific comment about its efficacy, side effects, interactions, and way to discontinue its use, if clinically appropriate. Summary: The Monitoring Team noted significant improvement with the comprehensiveness of pharmacy completion of the QDRRs, and review and follow-up by physicians. The Monitoring Team noted that the QDRR summaries were not organized in any specific way, and strongly recommends that the pharmacist document all relevant components of the QDRR in sections. Because the pharmacy was significantly behind with completing QDRRs timely, the Monitoring Team determined that the Facility was not in compliance with Provision N2.	Noncompliance
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	To assess the Facility's ability to monitor the use of stat psychotropic medication for chemical restraint, polypharmacy, anticholinergic medications, and assessment of metabolic syndrome for individuals who were prescribed antipsychotic medications, the Monitoring Team requested all data; data analysis; summaries for systems review of anticholinergics, benzodiazepines, stat chemical restraints, and anticholinergic medications; all corresponding committee meeting minutes; and the most recent QDRRs for the last ten individuals from a list of all individuals who were prescribed an anticholinergic, benzodiazepine, polypharmacy, or stat medication for chemical restraint.	Noncompliance

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	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.	Review of Anticholinergics The Monitoring Team was provided data tables that were dated 9/12 through 4/13. The data sheet indicated that an average of 18 individuals were prescribed an anticholinergic. The data tables were for the specific the types of anticholinergics prescribed, and indication, but there was no discussion about plans to reduce the use of anticholinergics, when possible. Also, review of the P&TC meeting minutes that were provided (9/26/2013, and 12/19/2013) did not reflect a comprehensive review of anticholinergic use. Review of the ten QDRRs of Individuals who were prescribed an anticholinergic did not indicate a comprehensive review of the anticholinergic medication. In fact, zero out of 15 (0%) indicated a review for the appropriate use of anticholinergics. Review of Benzodiazepines The Monitoring Team was provided a list of all individuals prescribed scheduled benzodiazepines; data tables that were dated 9/12 through 4/13, and indicated that an average of 26 individuals were prescribed benzodiazepine. But there was no systems review, along with recommendations on possible means to reduce the use of benzodiazepines, when appropriate. Also, P&TC meeting minutes that were provided (9/26/2013, and 12/19/2013) did not reflect review of benzodiazepine use. In zero of the first ten QDRRs from the list of all individuals prescribed scheduled benzodiazepines (0%) was there a comprehensive review of benzodiazepine use, that included if the drug was used appropriately, and if the drug could be discontinued or could be decreased. In three out of ten cases (30%) there was some mention about drug interaction with benzodiazepines. Review of Polypharmacy To determine if the Facility provided a mechanism that includes a system review of the use of polypharmacy at the Facility, the Monitoring Team attended the Facility's polypharmacy meeting, reviewed the procedure for the polypharmacy meeting, and requested that last six months of the polypharmacy committee minutes, including all data, graphs, and data analysis. Review the of psychiatric polypharmacy committee procedure found that there was no process to ensure that a systems review for the use of polypharmacy occurred. Also, there was no process to ensure that all individuals who were prescribed psychotropic polypharmacy were reviewed at least quarterly. The polypharmacy committee meeting that was attended by the Monitoring Team demonstrated the committee provided a comprehensive review of the two Individuals	

#	Provision	Assessment of Status	Compliance
		reviewed at the meeting. It was evident that the committee members, explored the risk and benefits of polypharmacy for the individuals cases reviewed. There was no evidence that a system wide review of polypharmacy was done. The nurse member of the committee informed the Monitoring Team that since the committee had just recently started, they had not yet determined what data elements they would use for a future systems review and analysis. Review of the past six months of polypharmacy meeting minutes indicated that there were a total of four meetings, that took place since the committee started in February, 2013 (February 19, March 26, April 26, and May 13, 2013). Review of the minutes demonstrated excellent review of clinical issues associated with individual cases of polypharmacy. The Monitoring Team noted that there were no formal action plans and associated assignment of a responsible person to ensure development and implementation, nor was there follow-up on the action plan, or a specific timeframe when a action plan should be completed or reviewed. For example, in the April 23, 2013 minutes, there was a discussion that "all medications should reconcile with the medical records and everything should match CWS" and "patients should have EKG and be monitored for any mood or behavior changes". There was no plan to address these concerns, and to assess if all medication did in fact reconcile with the medical records and CWS. The March 26, 2013 minutes documented that "charts will be audited on a monthly basis to see if anything has changed", and there was no associated action plan or responsible person. The May 13, 2013 minutes documented that "Dr. Moron requested that the work group create a high risk poly-pharmacy group so that these individuals are periodically reviewed", but there was no responsible person assigned, no specific action plan developed, and no completion date stated. Such examples were pervasive throughout the minutes reviewed. Also, the minutes did not reflect on a review of system wide data, trends analysis and action plan to reduce polypharmacy from a systems perspective. The Monitoring Team reviewed the QDRRs of the first ten individuals on a list of all individuals on psychiatric polypharmacy. In zero out of ten (0%), the pharmacist documented a comprehensive review of the individual's use of polypharmacy, discussed relative risks associated with polypharmacy, and provided clinically relevant recommendations for eliminating or decreasing the use of polypharmacy, when clinically justifiable. <u>Review of Stat Medications</u> The Monitoring Team reviewed the P&TC minutes for 9/25/2012 and 12/19/2012. The minutes did not delineate a comprehensive systems review of stat chemical restraint. Review of a stat medication data sheet, dated 9/2012 through 4/2013, documented the	

#	Provision	Assessment of Status	Compliance
		number of chemical restraints that occurred in the given time period, and the type of medication used for the stat chemical restraint. For that period, the Facility reported a total of seven stat chemical restraints. The stat sheets did not include monthly trends analysis, or methods to address potential systems issues related to the use of stat chemical restraints. Note that the Trend Analysis Report for April 2013 showed one use of chemical restraint during a behavioral crisis for the period from November 2012 through April 2013, and six uses for the period from May 2012 through October 2012, as reported in Provision C1. The Monitoring Team requested a list of all individuals who were provided a stat psychiatric chemical restraint during the reporting period and requested that the QDRR, and face to face debriefing form be provided for the last ten chemical restraints administered at the Facility. The Monitoring Team was provided a copy of three crisis intervention restraint checklists that included a post-chemical restraint clinical review, for the psychiatrist and pharmacist to complete (Individuals #77, #40, and #139). In zero out of three cases (0%) did the pharmacist conduct a comprehensive review of for use of stat chemical restraint that included a statement of whether the use was justifiable, appropriate dose, potential interactions, and all relevant side effects. In zero out of three cases (0%), was there evidence on the post chemical restraint clinical review of psychiatrist review of appropriateness of use of the drug, if alternative treatments including behavioral approaches could have been used, and if the current scheduled medications were appropriate or should be changed. <u>Review of Metabolic Syndrome</u> Review of the P&TC subcommittee meeting minutes provided (9/25/2012 and 12/19/2012), provided no evidence that a comprehensive review of system issues related to metabolic syndrome was done for individuals on antipsychotic medications. The Committee should regularly review this population, and assess ways of reducing the risk to individuals from metabolic syndrome, at the Facility level. The Monitoring Team requested a list of all Individuals known to have metabolic syndrome; however, no list was provided. The Monitoring Team requested a list of all individuals known to be on an antipsychotic medication, and had diabetes, and/or hypertension, and/or hyperlipidemia. From that list the Monitoring Team requested the QDRRs, of the last ten individuals. Of the ten cases reviewed, six out of ten (60%) documented a summary of potential and known risk for metabolic syndrome. Of the six cases that documented potential and known risk for metabolic syndrome, four out of six (67%) documented clinically relevant recommendations for the physician.	

#	Provision	Assessment of Status	Compliance
		Summary: The Monitoring Team has noted many improvements in developing and implementing action plans towards compliance with Provision N.3. For example, the new polypharmacy committee will help reduce the use of polypharmacy, the Facility had improved collecting data on the use of stat medications, and improved on assessment of metabolic syndrome. Substantial compliance will require continued improvement by enhancing systems to review each of these issues. The Facility must also ensure that the QDRR process provides a specific and comprehensive review of the use of polypharmacy, anticholinergics, benzodiazepines, stat chemical restraint for psychiatric indications, and metabolic syndrome.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	To determine if the Facility ensured appropriate follow-up to pharmacy recommendations, the Monitoring Team reviewed the first ten single patient drug interventions (SPDI) that occurred in February, 2013, and the most recent 15 prescription written for a new medication (same sample as for Provision N.1 of this report). Review of the last 15 prescriptions for new medications indicated that: • In 15 out of 15 cases (100%), the primary care provider, and when clinically indicated, the psychiatrist, documented acceptance or rejection of the pharmacists recommendations. o In those cases that were rejected, there was clinically justifiable rationale, with an associated action plan, documented by the appropriate physician Review of the first ten SPDIs that occurred in February, 2013 indicated that: • Ten out of ten (100%) indicated comprehensive documentation by the pharmacist of the SPDI. • Ten out of ten (100%) included written documentation that the pharmacist notified the physician of the SPDI. • Ten out of ten (100%) included clinically justifiable recommendations regarding the SPDI by the pharmacist. • Seven out of ten (70%) included written documentation by the physician indicating review of the pharmacists recommendations. o In the three cases that the physician did not document a review, the physician wrote an order corroborating the pharmacist's recommendation. • The physician concurred with the pharmacist's recommendation in nine out of ten cases (90%). o In the one case that the physician disagreed with the pharmacist's recommendation, the physician documented a justifiable rationale, and referred the Individual for a neurology consultation.	Substantial Compliance

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		Summary: The Monitoring Team was most impressed with the pharmacy's process for assessing, documenting, and reporting of SPDIs. The pharmacists ensured precise documentation of the issue, ensured that the prescribing physician was notified of the issue, and followed up through resolution, ensuring that the issue was appropriately managed. The Monitoring Team noted that the prescribing physician appropriately managed recommendations made through the QDRR process. The Monitoring Team congratulates the pharmacist, and prescribing physicians, for developing and implementing a process that has resulted in substantial compliance for Provision N.4, of th Settlement Agreement.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	To assess if the Facility monitors side effects, including Tardive Dyskinesia, for Individuals receiving neuroleptic medication, the Monitoring Team requested an alpha list of all Individuals who were prescribed a new antipsychotic medication, and an alpha list of all Individuals who had a dose increased of their prescribed neuroleptic medication, within the past six months, and all associated MOSES and DISCUS reports, for the first ten individuals on the lists. The completed document request noted that no Individuals were prescribed a new neuroleptic, and only five individuals were prescribed dose increase for the previously prescribed neuroleptic. Of the six Individuals who were prescribed a dose increase in their neuroleptic (#81, #77, #139, #46, #63, #84), a total of 11 MOSES, and 11 DISCUS assessment forms were provided for review. • Of the 11 MOSES assessment forms, the examiner component was fully completed in 9 of the 11 samples (82%). • Of the 11 DISCUS assessment forms, the examiner component was fully completed in 9 of the 11 samples (82%). • Of the 11 MOSES assessment forms, the prescriber component was fully completed in ten out of 11 samples (91%). • Of the 11 DISCUS assessment forms, the prescriber component was fully completed in ten out of 11 samples (91%). • Of the 22 assessment forms provided for review, 22 out of 22 (100%) were signed by the physician within seven days from the date of the assessment. • Of the six individuals who were provided an increased dose of a neuroleptic, five of the six (83%) were provided more frequent monitoring of side effects by completion of at least one additional MOSES and DISCUS assessment, following the dose increase. • Of the six individuals who were provided an increased dose of a neuroleptic, six out of six (100%) were provided routine screening for side effects of	Substantial Compliance

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		neuroleptics, within the past six month period. Summary The Monitoring Team compliments the Facility for enhancing its monitoring of side effects of individuals who were prescribed neuroleptic medication. The Monitoring Team noted that all six individuals were provided enhanced monitoring by means of both the DISCUS and MOSES assessments, following a dose increase of a neuroleptic. Also, the Facility ensured that MOSES and DISCUS assessments were completed routinely, and assessment forms were reviewed and signed by the prescriber within seven days from the date of the assessment.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	To assess the Facility's ability to identify, report, clinically manage, track, and trend adverse drug reactions, the Monitoring Team request copies of all data and trends analysis of adverse drug reactions (ADRs) reported by the Facility; copies of all training materials, and sign in rosters of staff who completed training on ADRs; list of all ADRs reported during the last six months; copies of the last ten ADR completed forms and action plan; and all committee meeting minutes that documented a review of ADRs during the reporting period. <u>List of ADRs</u> The Monitoring Team was informed that only one ADR was reported during the reported period (Individual #66). <u>Training on Identifying and Reporting of ADRs</u> The Facility had an efficient and effective training tool on identifying and reporting ADRs. A total of 21 staff were reported to have been trained. The Monitoring Team noted, however, that no physicians or pharmacists had completed such training. <u>Completed ADR forms</u> One form was provided for review (#66): • The physician did not complete the physician section. • It was not documented that the P&TC had reviewed the ADR, and made recommendations. • The type of reaction was limited to only two classifications/severity levels. • There was no place on the form indicating if notification of the FDA was necessary or not, and no area to document notification of the FDA, when necessary. <u>P&TC Meeting Minutes</u> Only one set of P&TC meeting minutes were provided that documented ADR as a topic,	Noncompliance

#	Provision	Assessment of Status	Compliance
		during the reporting period (12/19/2012). The only comment made about ADRs was that the issue of ADRs was "tabled". There was no discussion about the ADR that occurred to Individual #66. Review of Data, and Trends Analysis for ADRs The Facility reported that it did not maintain data, or conduct trends analysis on ADRs. Summary: The Monitoring Team determined noncompliance for Provision N6, and strongly encourages the Facility to develop and implement a robust ADR process, by enhancing the ADR reporting form; ensuring that all relevant staff are trained on identifying and reporting of ADRs (including physicians, pharmacy staff, nurses, direct care staff, and others who are regularly in contact with individuals); ensuring that the reporting forms are completed in full, and accurately; ensuring that FDA reportable ADRs are reported to the FDA immediately; and conducting regular review of ADR data, and trends analysis.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	To assess the Facility's Drug Utilization Evaluation (DUE) process, the Monitoring Team requested copies of all relevant committee meeting minutes that addressed ADRs during the past six months, a copy of the DUE schedule, policy and procedure for the DUE process, and a copy of all DUEs provided during the reporting period. Review of Committee Meeting Minutes: The Monitoring Team reviewed the December 19, 2012 P&TC committee meeting minutes and noted that DUEs were not addressed at the meeting. Review of the DUE Schedule The DUE schedule did not delineate the type of DUE that was provided, or is pending. Review of DUEs Provided During the Reporting Period There were two reported DUEs provided during the reporting period. One was for the use of Geodon, and one for Clozaril. The DUEs were limited to a chart review of monitoring parameters for each drug. There was no discussion of the drug related to appropriate use, updated side effects, indications, contraindication, etc. There were also no recommendations for prescribers. DUEs Specific for FDA Alerts and Manufacturers Warnings There was no indication that specific DUEs were developed for FDA advisories that occurred during the reporting period. For example, the FDA issued advisories: • Azithromycin warning about fatal cardiac arrhythmias on 3/12/2013 • Pradaxa warning about life threatening bleeding on 11/2/2013	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Facility must ensure that prescribers are made aware of all relevant advisories and warnings, and when Individuals are prescribed such a drug, a comprehensive review of issue must take place, to ensure that clinical practice aligns with any know warning and advisory. Summary: The Monitoring Team determined that the Facility remained not in compliance with Provision N7. Substantial Compliance will require the Facility to enhance its current DUE process by ensuring that DUE selection of at least one drug or drug category be selected for by the P&TC committee for each Quarter during the year. In addition, the Facility must implement a DUE for all FDA advisories and manufacturers warnings. A schedule must be maintained that tracks all delivered and pending DUEs, as well as follow-up on DUE initiated action plans. Action plans must be developed, implemented, and tracked for each DUE, as clinically necessary. A DUE must include assessment of the drug by assessing monitoring parameters, such as laboratory data, include a summary of all relevant clinical issues, provide recommendations for the prescriber, and a process to ensure that recommendations are completed and effective. The P&TC should review all DUEs and ensure that recommendations are clinically appropriate, and that the Facility adheres to recommendations.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	To assess the Facility's medication variance process, the Monitoring Team reviewed all relevant committee meeting minutes; all staffing training and sign in sheets specific to training on medication variances; copy of all data, trends analysis, summaries, and action plans developed for medication variances; copy of the procedure used specific for medication variances provided by the Facility. <u>Policy Review</u> The Monitoring Team reviewed the Facility's medication variance policy - RGSC Policy: Standard Operating Procedure NR100-66: Medication Error Policy, revised 12/2007. The policy was outdated, as it was scheduled to be revised in 2008. Review of the policy indicated that it did not reflect current changes that have been made with regards to medication variance processes at the Facility. The Policy focused mostly on nursing variances, and not physician or pharmacy related variances. The policy used antiquated terminology, such as "error" instead of variance. As noted in Provision M6, though, the Facility also provided RGSC SOP PH 100-017-01-09 revised March 2011. However, it also was out of date, as it had not been revised since DADS implemented Policy 053 Medication Variance Policy, and the two policies were not entirely consistent. <u>Review of Training Material and Sign In Sheets For Training on Medication Variances</u>	Noncompliance

#	Provision	Assessment of Status	Compliance
		There was no information provided on medication variance training. Review of Data, Data Analysis, and Action Plans for Medication Variances The Facility maintained monthly data for medication variances. Specific data elements included the category of error; living area that the variance occurred; initial of specific staff involved; and type of variance. The Monitoring Team was provided copies of data reports for 12/2012 through 4/2013, and a review for quarter three, 2013. There were no data reports provided for November 2012, or for review of quarter two. Specific to medication variance, the Facility reported the following medication variances:	

	EP	LA	TTL
Sep-12	87	0	87
Oct-12	0	1	1
Nov-12	0	0	0
Dec-12	0	1	1
Jan-13	0	4	4
Feb-13	1	5	6
Mar-13	8	7	15
Apr-13	1	3	4
May-13	0	1	2
TTL	97	22	119

Note: EP=El Paisano; LP=La Paloma

The Facility reported that from 09/2012 through 5/10/2013 a total of 11 category A variances; two category B variances; 105 category C variances; and one category F variances (see Provision M6 for description of categories).

Although the medication variance data indicated specific staff members, by initials, who manifested the variance, the report did not differentiate what department was involved, such as nursing, pharmacy, and physician services. Variances should be identified by

#	Provision	Assessment of Status	Compliance
		department. Although the variances were differentiated between living areas, the Monitoring Team questions how the Facility tracks medication variances that may occur at vocational education. The Monitoring Team did not identify a comprehensive trends analysis completed for the data, and there was no evidence of action plans being developed to address medication variances on a consistent basis. Also provided for review was a RGSC: ICF Medication Investigation Summary Report for 12/1/2012 through 5/10/2013. The Data Reports were noted to be an efficient, and effective means of maintaining data specific to each medication variance analyzed. <u>Review of Committee Meeting Minutes</u> The Monitoring Team was provided with copies of medication management workgroup notes for 11/20/2012, 12/18/2012, 1/29/2013, 2/19/2013, and 4/1/2013 The Facility did not provide P&TC minutes to reflect review of medication variances: • With the exception of the 12/18/2012 notes, that did review data on medication variances, none of the notes reflects a specific review of medication variances, development of a trends analysis, summarized variance data, or determined if remediation was necessary. • In general, new business items identified in the notes, were not consistently assigned an action plan or follow-up date. Summary The Monitoring Team was impressed with the efforts to develop a functional medication variance process. A new workgroup, called the medication management workgroup, has been meeting monthly and is focusing on developing the infrastructure for the Facility's medication variance process. Medication variance data was being collected, and categorized on a monthly basis. Members of the workgroup should be recognized for the efforts in moving forward towards compliance with Provision N.8. At the time of this review, the Monitoring Team determined that the Facility continued noncompliance with Provision N.8, and strongly encourages the Facility to move assertively to implement a robust medication variance process. The Facility must ensure medication variances are differentiated by discipline, such as nursing, pharmacy, and physician services; there must be a robust trends analysis completed for the data monthly, and summarized quarterly; a process for staff remediation, and when necessary, administrative action, must be developed; action plans and follow-up to action plans must be developed for all relevant variances; the P&TC committee must review all medication variance data,	

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		analysis, and action plans, follow-up to actions plans, remediation, administrative actions, and provide comments and recommendations for the medication variance workgroup. The medication variance workgroup, should identify a chairperson, and ensure that department leadership for nursing, pharmacy, and physician services attend each meeting of the workgroup. The medication variance policy must be updated to reflect the Facility's current practice.	

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

1. Ensure that the pharmacist documents a review of all new medication orders at the time of dispensing a new medication. (Provision N.1)
2. Ensure that QDRRs are completed quarterly for all individuals. (Provision N.2)
3. The QDRR process must be enhanced by ensuring clinically relevant issues, such as metabolic syndrome, the use of benzodiazepines, anticholinergics, polypharmacy, and stat medications for psychiatric indications are summarized betters, and when clinically appropriate, recommendations to reduce the use of such drugs. (Provision N.3)
4. Ensure that all MOSES and DISCUS assessments are completed at least quarterly, and more frequently as clinically indicated. (Provision N.5)
5. Improve the adverse drug reaction process by enhancing training for all relevant staff, ensure that reporting forms are completed accurately, that there is a process to notify the FDA of ADRs, when necessary, and ensure that ADRs are tracked, trended, and reviewed at the P&TC. (Provision N.6)
6. Develop and implement a DUE process that ensures quarterly scheduled DUEs, selected by the P&TC committee members, and for all relevant FDA advisories, and manufacturer warnings. (Provision N.7)
7. The Facility must enhance its medication variance process. (Provision N.8)

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** ▪ RGSC Self-Assessment, dated 4/29/13 ▪ RGSC Action Plan 4/25/13 ▪ RGSC Physical and Nutritional Management Policy (rev 4-2013-draft) Record reviews: ▪ Sample O.1: Individuals #19, #35, #40, #47, #60, #79, #108, #114, #115, #126, #139 and #143 ▪ Sample O.2: Individuals #19, and #108 ▪ Sample O.3: Individuals #19, #47, #79, and #126 ▪ Sample O.4: Individuals: #8, #11, #29, #36, #46, #51, #66, #74, #85, #94, #97, #98, #101, #119, and #139 ▪ Sample O.5: Individuals #2, #5, #59, and #150 ▪ Lists of individuals: o Who cannot feed himself or herself and notation of any changes since the last review; o Who require positioning assistance associated with swallowing activities and notation of any changes since the last review; o Who have difficulty swallowing and notation of any changes since the last review; o At high and/or medium risk for aspiration pneumonia and choking; o With choking incidents since the last compliance review o Who had a feeding tube inserted since the last compliance review o Who were admitted to the hospital since the last compliance visit with admitting and discharge date and diagnosis o Who were diagnosed with pneumonia or a respiratory difficulty since the last compliance review (include date and type) o With falls in the last 12 months (date, location , type of injury)* o With chronic respiratory infections o With chronic dehydration o With fecal impaction o With pressure ulcers in the last 12 months (date, location and resolution) o With fractures in the last year (date, location of fracture, status) o Who were non-ambulatory or require assisted ambulation o With wheelchairs for primary mobility o With wheelchairs for transport o Who use Assistive Devices for ambulation (type of device) o With orthotic/braces ▪ New PNMT members since last review, including a copy of their curriculum vita; ▪ Caseloads of PNMT dedicated and non-dedicated members.

	▪ List of medical consultants to the PNMT (e.g., medical doctor, nurse practitioner, or physician's assistant) and PNMT meeting minutes and attendance sheets for presence and participation of a medical doctor, nurse practitioner or physician assistant, and other IDT members as needed or defined in Facility policy. ▪ PNMT members and PNMT back up members curriculum vitas ▪ QA reports/matrix since the last compliance review ▪ List of referrals to the PNMT since the last compliance visit ▪ PNMT RN post hospitalization assessments completed since the last compliance visit ▪ PNMT assessment template ▪ PNMT Action Plan template ▪ IRRF template ▪ IHCP template ▪ Compliance Monitoring Form guiding questions sheet ▪ List of new employees since last compliance visit and their PNM related performance check offs ▪ List of staff assigned to train other staff on the PNM core competencies (i.e., foundational skills) and dates of training, including back-up training records (i.e., sign-in sheets and competency check-offs) ▪ Facility documentation showing categories of staff requiring annual refresher training, numbers of staff requiring training, and numbers of staff who have successfully completed training; ▪ PNM Monitoring Tool template ▪ Last three months of PNM monitoring data (including date, activity monitored, time of monitor, person conducting monitor) ▪ For Individuals in Samples 0.1 to 0.5: o All ISPs in the last 12 months o All ISPAs in the last 12 months o All IRRFs in the last 12 months o All IRRF Action Plans in the last 12 months o IHCP/Action Plan o QDDP Monthly Reviews for the last 6 months o Braden Scale forms o Annual weight graph o Nutrition tab, including assessments and reviews o Head of Bed Elevation (HOBE) assessments o PNMT assessments and any other PNMT documentation other than IPNs in the last 12 months, if not already submitted o OT/PT assessments in the last 12 months o SLP assessments, including Communication/AAC in the last 12 months o 6 months IPNs o Trigger sheets completed in the last 6 months, including the current one o PNMPs in the last 12 months, including pictures o Dining Plans in the last 12 months, including pictures o Completed PNM-related monitoring sheets in the last three months

	o Evidence of effectiveness monitoring completed within the last six months o Aspiration Pneumonia Enteral Nutrition (APEN) in the last 6 months o Plan for individuals who are returning to oral eating and supporting documentation for implementation of plan (i.e, staff training documentation, staff roles and responsibilities, specific triggers when the plan should be stopped; milestones for progress with the plan, documentation requirements to track progress, and frequency of subsequent assessments and staff responsible and monthly progress notes) o Direct intervention plan and supporting documentation for implementation of the plan (i.e., monthly progress notes) o Individual notebooks (PNM section) **People Interviewed:** ▪ Jane Augustine PT Director of Habilitation Services ▪ Belinda Lopez SLP ▪ Pamela Hawxhurst OTR ▪ Betty Perez Rehab Tech II ▪ Marcy Valdez RN ▪ Six direct care staff (3 La Paloma, 3 El Paisano) **Meeting Attended/Observations:** 1. PNMT meeting 5/14/13 2. Morning Medical meeting 5/16/13 3. Mealtimes and Transitions (La Paloma, El Paisano)
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, dated 4/29/13, and Action Plan dated 4/25/13. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section O, in conducting its self-assessment, the Facility: • Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section O. o This monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. For example, the Self Assessment for Provision O.1 did not include review of the PNM policy. o The monitoring tools did include adequate methodologies, such as observations, record review and staff interview. For example, the Settlement Agreement Monitoring Tool guidelines instructed the reviewer to review a PNMT assessment, staff training records, complete observation(s) of individual's PNMP being

	implemented, and conduct staff interviews to ask staff why the individual requires PNMP interventions. o The Self-Assessment did identify the sample(s) sizes but lacked the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). o The Self-Assessment did not state the staff/positions who were responsible for completing the audit tools; therefore there was no evidence of staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools. • The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. • The Facility rated itself as not being in compliance with any of the provisions of Section O. This was consistent with the Monitoring Team's findings. The Actions plans developed were felt to move RGSC in the right direction towards compliance; however, RGSC should continue to review the findings of the Monitor's report and revise the Action Plans as indicated to address all identified concerns. Development and implementation of methods to gauge quality and not just presence should be investigated and integrated as part of the Action Plan.
	Summary of Monitor's Assessment: Overall, RGSC appeared to moving in a positive direction with regards to providing physical and nutritional services. Improvement was evident with the Physical and Nutritional Support Plans (PNMPs) as they were noted be more comprehensive in addressing all areas in which physical and nutritional risk may be increased. The PNMT met regularly, which was positive, and 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 had shown improvement. The monitoring system, while more formal, remained unclear regarding the criteria in which individuals received certain levels of monitoring. **Provision O.1:** This provision was determined to be not in compliance. Areas of need included development of a comprehensive PNM policy and the consistent presence of an Occupational Therapist (OT) as a member of the Physical and Nutritional Management Team (PNMT) **Provision O.2:** This provision was determined to be not in compliance. RGSC continues to have difficulty identifying those individuals who are at risk and assigning the appropriate risk classification as it relates to issues related to PNM. There was also a lack of integration of the PNMT recommendations into the ISP.

	Provision O.3: This provision was determined to be not in compliance. PNMPs were not comprehensive due to the plans lacking detailed information regarding oral care and dental. **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. **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. While there was evidence of staff training, there was no clear method to determine if staff had received training prior to working with individuals, as there was no date signifying training was completed. RGSC was unable to identify staff who had completed or were in need of completing annual refresher training classes relevant to PNM. **Provision O.6:** This provision was determined to be not in compliance. There was no evidence that staff or the individual was monitored across all three shifts. **Provision O.7:** This provision was determined to be not in compliance. Clear criteria indicating progress and effectiveness were not integrated into the IHCP and monitored by the PNMT. Additionally, the risk process was determined by the Monitoring Team to remain lacking in its ability to detect risk as only 60% of the individuals reviewed were judged to be provided with an accurate risk score and therefore monitoring did not occur based on the Individual's true level of risk. **Provision O.8:** This provision was determined to be not in compliance. The Monitoring Team was unable to determine if the plan for returning to oral eating was based on the results of the IDT's discussion and was integrated in the IHCP, ISP, and/or an ISPA since the plan had not yet been developed at the time of the review. The IRRF did not provide clinical assessment data to identify an individual's potential to return to oral eating. IRRFs did not provide justification for the medical necessity of the feeding tube. Additionally, any plan the IDT develops should be memorialized in an IHCP that is part of the ISP, and/or documented in an ISPA.

#	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	The following samples were utilized for Section O: Sample O.1 consisted of a non-random sample of 12 individuals who were chosen from a list provided by the facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis],	Noncompliance

#	Provision	Assessment of Status	Compliance
	services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional	require mealtime assistance and/or are prescribed a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. Sample O.2 consisted of two individuals or 100% of the individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. Sample O.3 consisted of four individuals at RGSC who received enteral nutrition. Sample O.4 consisted of individuals observed in homes and day programs throughout the day. Sample O.5 consisted of four individuals who experienced a downgrade in diet texture since the previous compliance visit. <u>PNM Policy and Role of the PNMT:</u> The Facility did not have a comprehensive PNM policy that included the following elements: ▪ Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); ▪ The annual review process of an individual's PNMP as part of the individual's ISP; ▪ The development and implementation of an individual's PNMP shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; ▪ The roles and responsibilities of the PNMT; ▪ The composition of the Facility Physical and Nutritional Management Team (i.e., registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders) to address individuals' physical and nutritional management needs; ▪ Description of the role and responsibilities of PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); ▪ The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; ▪ Requirements for continuing education for PNMT members; ▪ Referral process and entrance criteria for the PNMT; ▪ Discharge criteria from the PNMT;	

#	Provision	Assessment of Status	Compliance
	management needs.	▪ Assessment process; ▪ Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; ▪ The PNMT consultation process with the IDT; ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; ▪ PNMT follow-up; ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; ▪ A comprehensive PNM monitoring process designed to addresses all areas of the PNMP, including: • Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, • Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, actions required based on findings of monitoring (for individual staff or system-wide), • Identification of monitors and their roles and responsibilities, • Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, • 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 • Frequency of monitoring to be provided to all levels of risk. • A system of effectiveness monitoring; and ▪ Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. The system should include: o Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; o Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT is collected, trended, and analyzed; o Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Morning meeting, QA/QI meeting): o A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan).	

#	Provision	Assessment of Status	Compliance
		o Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary and o If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate to measure the resolution of systemic issues. An example of an indicator that was absent included how the PNMT assisted in the Quality Review process as it related to systemic PNM related issues. Although the QA portion may fall primarily outside the realm of PNM, the PNMT's role in reviewing and identifying these issues as well as their contribution to the QA component should be noted. Other policy indicators missing included but were not limited to: ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; ▪ Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, ▪ Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician <u>Core PNMT Membership</u>: Based on interview with the Director of HT and review of PNMT minutes, the Facility PNMT did have the appropriate disciplines as defined in the Settlement Agreement. RGSC had identified the Registered Nurse (RN), Registered Dietitian (RD), Physical Therapist (PT), Speech Language Pathologist (SLP), and Occupational Therapist (OT) as standing core members with back-up members identified for the SLP. No other back up members were identified. There was only one PT and OT on staff therefore a backup was not available, There was the opportunity to have a back up for the RN position but this was not noted. <u>Consultation with Medical Providers and IDT Members</u> For two of two individuals in Sample O.2 (100%), evidence was provided of routine participation of medical staff in meetings, review of assessments, and other needed activities. For two of two individuals in Sample O.2 (100%), evidence was provided of routine participation of IDT members in meetings, review of assessments, and other needed activities.	

#	Provision	Assessment of Status	Compliance
		Qualifications of PNMT Members Six of six core and back up PNMT members (100%) were licensed to practice in the state of Texas. Six of six core and back up PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. Continuing Education Six of six core PNMT staff (100%) had completed at least 12 hours of continuing education directly related to physical and nutritional supports and transferrable to the population served within the past 12 months. Examples of continuing education included but were not limited to: • PT attended: Issues with Evaluation and Treatment of Individuals with Developmental Disabilities • SLP attended: Issues with Evaluation and Treatment of Individuals with Developmental Disabilities • OT attended: Medication Administration and Issues in Evaluation and Treatment of Individuals with Developmental Disabilities • RD attended: Dysphagia: A Growing Concern in Healthcare • RN attended: Medication Administration for Nurses and Issues in Evaluation and Treatment of Individuals with Developmental Disabilities PNMT Meetings From 12/2/12 to 4/2/13, of the 18 weeks, the team met on 17 of 18 weeks (94%). Core members of the PNMT were not consistently present for at least 80% of the meetings. It is important for each core member to participate regularly and consistently. Attendance by core PNMT members for 17 meetings conducted during the time frame from 12/2/12 to 4/2/13 was: ▪ Chairperson/Coordinator/PT: 76% attendance. (there was no back up for PT) ▪ RN: 76% attendance by core member, (there was no back up for RN) • OT: 47% attendance by core member, (there was no back up for OT) • SLP: 70% attendance by core member, 88% for back-up member, and 100% overall • RD: 94% attendance by core member (there was no back up for RD) Seventeen of 17 PNMT meeting minutes (100%) include documentation of appropriate topics: a) referrals; b) review of individual health status; c) PNMT actions; d) follow-up;	

#	Provision	Assessment of Status	Compliance
		and e) outcomes/progress toward established goals and exit criteria for individuals in the sample. The Facility PNMT did not have a sustainable system fully implemented for resolution of systemic issues/concerns. Missing from the system was: • How monitoring data from the QA Department as well as Habilitation Therapies and the PNMT was collected, trended, and analyzed; • How Habilitation Therapies and the PNMT identified and presented systemic issues requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Morning meeting, QA/QI meeting).	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	<u>Identification of PNM risk</u> Sixty-three of 63 individuals (100%) who cannot feed himself or herself, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems") had a PNMP. The Facility had a sustainable system to maintain and update lists of each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"). RGSC continues to have difficulty identifying those individuals who are at risk and assigning the appropriate risk classification as it relates to issues related to PNM. Six of ten individuals in Samples O.1 and O.2 (60%) were provided with an accurate risk score related to all of the PNM risk areas (i.e., respiratory compromise, GI, skin breakdown, falls, fractures, aspiration, and choking, or others relevant to specific individuals). Examples in which risk was not accurately identified included: ▪ Individual #47 was listed as high risk of aspiration but low risk of respiratory compromise. If an individual is at risk of aspiration then the risk of compromise to the respiratory system is increased as aspiration directly impacts respiration. ▪ Individual #139 was noted per Swallow Study (MBSS) to have delayed laryngeal closure but was listed as being at "Low" risk for aspiration. Another concern was the inconsistency of identified risk levels between different documents. Please see Provision O.3 for information. <u>Physical and Nutritional Management Team Referral Process</u>	Noncompliance

#	Provision	Assessment of Status	Compliance
		Two of two individuals from Sample O.1 (100%) were appropriately referred to the PNMT based on the criteria included in the Facility policy. In two of the two individual records reviewed from Sample O.1 (100%), when an individual experienced a change in status that would initiate a referral to the PNMT, there was evidence of referral to the PNMT within five working days of the ISPA meeting. A method in which the PNMT was made aware of changes in status was through participation by the PNMT lead and PNMT RN in the morning medical meeting. Information from this meeting was then brought to weekly PNMT meeting for further discussion and shared with the IDT as indicated if not already done so. There was a QA component to the PNMT in which data relevant to physical and nutritional supports are reviewed and analyzed by the team. Reviewing and identifying trends and the root cause of these trends will allow the PNMT to streamline and pinpoint trainings and/or assessments in an effort to prevent future occurrences, as well as identify other improvements and corrective actions that should be addressed. Participation in the Provision of Care meeting as well as the morning medical has resulted in improvement in the ability to identify issues occurring throughout the Facility. Three of three individuals from Sample O.1 who received a feeding tube (not on an emergency basis) since the last review (100%) had been referred to or discussed by the PNMT prior to the placement of the tube. No individuals at RGSC received an emergency feeding tube placement since the last review. <u>PNMT Assessment</u> The Monitoring Team was unable to determine if PNMT assessments/reviews for individuals in Sample O.2 (100%) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). The PNMT evaluation did not have a clear referral date nor was the Monitoring Team able to determine the referral date per review of the PNMT minutes. The Monitoring Team was unable to determine if the PNMT assessments in Sample O.2 (100%) were completed in no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances due to their being a lack of a clear date regarding referral and initiation of assessment.	

#	Provision	Assessment of Status	Compliance
		Based on review of individuals' records who were referred to the PNMT (Sample O.2), the comprehensiveness of the PNMT assessment components were as follows: ▪ Zero of two (0%) contained date of referral by the IDT. This information was not contained within the ISPA, ISP and/or PNMT assessment ▪ Zero of two (0%) contained date assessment was initiated. This information was not contained within the PNMT assessment, or PNMT minutes. ▪ Two of two (100%) contained evidence of review and analysis of the individual's medical history. This information was contained as part of the PNMT RN Assessment and PNMT evaluation. ▪ Two of two (100%) identified the individual's current risk rating(s), including the current rationale. This information was not contained within the IRRF, and and/or PNMT evaluation as indicated. ▪ Zero of two (0%) included updated risk ratings based on the PNMT's assessment and analysis of relevant data. This information was not contained within the IRRF, and/or PNMT evaluation as indicated. ▪ Two of two (100%) contained evidence of discussion of the individual's behaviors related to the provision of PNM supports and services, including problem behaviors and skill acquisition. ▪ Two of two (100%) contained assessment of current physical status. This information was contained within the PNMT minutes, the PNMT RN Assessment, and the PNM assessments. ▪ Two of two (100%) contained assessment of musculoskeletal status as indicated by the PNMT RN Assessment. ▪ Two of two (100%) contained evaluation of motor skills as indicated by the PNMT RN Assessment. ▪ Two of two (100%) contained evaluation of skin integrity as indicated by the PNMT RN Assessment. ▪ Two of two (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene. ▪ Zero of two (0%) contained evaluation of current adaptive equipment. This information was contained within the Habilitation Assessment but there was no evidence of review of this component when there was a PNMT referral to ensure accuracy. ▪ Two of two (100%) contained nutritional assessment, including but not limited to history of weight and height; intake, nutritional needs, and mealtime/feeding schedule. This information was contained within the Annual Nutritional Assessment, the PNM RN Assessment, as well as consults. ▪ Two of two (100%) contained evaluation of potential or actual drug/drug and drug nutrient interactions. ▪ Zero of one (0%) identified residual thresholds, if enterally nourished. ▪ Two of two (100%) contained a tableside oral motor/swallowing assessment,	

#	Provision	Assessment of Status	Compliance
		including but not limited to mealtime observation. ▪ Two of two (100%) contained respiratory status. This was contained within the PNMT RN Assessment and discussed as part of the PNMT meeting ▪ Two of two (100%) contained evidence of review/analysis of lab work. ▪ Two of two (100%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects. ▪ Two of two (100%) contained discussion as to whether existing supports were effective or appropriate. This information was contained within the PNMT RN Assessment as well as in the PNMT minutes and evaluation. ▪ Zero of two (0%) contained oral hygiene status. This information was contained within the Habilitation Assessment but there was no evidence of review of this component when there was a PNMT referral to ensure accuracy. ▪ Two of two (100%) contained evidence of observation of the individual's supports at their home and day/work programs. ▪ Two of two (100%) contained evidence that the PNMT conducted hands-on assessment. ▪ Two of two (100%) identified the potential causes of the individual's physical and nutritional management problems. This information was contained within the PNMT RN Assessment, PNMT Assessment and PNMT minutes. ▪ Two of two (100%) identified the physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rationale for the recommendations. This information was contained within the Habilitation Assessment as well as part of the PNMT RN Assessment, PNMT Assessment and PNMT minutes. ▪ Two of two (100%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. This information was contained as part of the PNMT Assessment, IRRF, PNMT minutes and ISPA. ▪ Two of two (100%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. This information was contained within the Habilitation Assessment as well as part of the PNMT Assessment and PNMT minutes. ▪ Two of Two (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e. revision of the individual's PNMP). ▪ Two of two (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT. ▪ Two of two (100%) contained signatures with dates. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs</u>	

#	Provision	Assessment of Status	Compliance
		For zero of two individuals (0%) in Sample O.2, all recommendations by the PNMT were addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. While 100% of the recommendations were clearly integrated as part of the ISPA and were included as part of the risk action plans primarily in the form of following the PNMP, recommendations were not clearly linked or integrated into the IHCPs. Plans resulting from PNMT recommendations for Sample O.2 included the following components: ▪ In two of the two individuals' plans reviewed (100%), the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. ▪ In two of the two individuals (100%) for whom HOBE assessments were conducted, the HOBE recommendations were integrated into individuals' plans. ▪ In two of the two individuals' plans reviewed (100%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. ▪ In zero of the two individuals' plans reviewed (0%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. ▪ In two of the two individuals' plans reviewed (100%), the plans included the specific clinical indicators of health status to be monitored. ▪ In zero the two individuals' plans reviewed (100%), the plans defined triggers. ▪ In two of the two individuals' plans reviewed (100%), the frequency of monitoring was included in the plans. <u>PNMT Follow-up and Problem Resolution</u> With regard to plan implementation for Individuals in Sample O.2: ▪ In zero of two individuals' documentation reviewed (0%), supporting documentation was present to confirm implementation of individuals' action plan within 14 days, or sooner as needed, of the plan's finalization. ▪ In zero of the two individuals' plans reviewed (0%), documentation was provided to show action plan steps had been completed within established timeframes, or IPNs/monthly reports provided an explanation for any delays and a plan for completing the action steps. <u>Individuals Discharged from the PNMT</u> For individuals discharged by the PNMT in Sample O.2: • One of one individual (100%) had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. This was signified by members of the IDT signing off on the actual PNMT assessment. • Zero of one individuals' (0%) discharge summary/action plan provided objective clinical data to justify the discharge.	

#	Provision	Assessment of Status	Compliance
		• Zero of one individuals' ISPA meeting documentation (0%) provided evidence that any new recommendations were integrated into the IHCP. • Zero of one individuals' ISPA documentation and/or action plan (0%) included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy. There was not a clear, consistent process that documented a collaborative discharge summary/action plan which included recommended supports and services, key clinical indicators, individualized triggers, guidelines for monitoring the individual's supports, services and triggers, objective clinical data to justify the discharge, evidence that discharge recommendations were integrated into the IHPC, and criteria for referral back to the PNMT integrated as part of the IHCP.	
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.	<u>Identification of Individuals Requiring a PNMP</u> For the ten individuals in Sample O.1, ten of their annual ISPs (100%) noted that the appropriate disciplines were present to approve and integrate the PNMP in the ISP. All annual ISPs reviewed documented at a minimum an Occupational (OT) or Physical Therapist (PT) as well as Speech Therapist (SLP) present to discuss the PNMP. Seven of 10 PNMPs (70%) were reviewed by the individual's IDT in the annual ISP meeting. The ISPs contained evidence of review, update/revision, and effectiveness, and specified the changes required to the PNMP. <u>PNMP Format and Content</u> A review of individuals' PNMPs from Samples O.1 and O.2 found: • PNMPs for 12 of 12 individuals (100%) were current within the last 12 months. • PNMPs for 12 of 12 individuals (100%) included a list of all high-risk levels and individual triggers as indicated • In 12 of 12 most current PNMPs (100%), there were large and clear color photographs with instructions. • 12 of 12 PNMPs (100%) listed the adaptive equipment required by the individual. Rationale regarding the need for the adaptive equipment was not present on the PNMP but was available as part of the Habilitation Therapy assessments. • In 12 of 12 PNMPs (100%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and pictorial instructions, were provided. • In 10 of 12 PNMPs (83%), positioning was adequately described per the individuals' assessments. Individuals #253 and #281 only had information	Noncompliance

#	Provision	Assessment of Status	Compliance
		regarding the use of the chain to help determine elevation and did not contain the degree of elevation on the PNMP. Only having a description of the chain does not easily transfer should the person move to a new bed. • In 12 of 12 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. • In 12 of 12 PNMPs (100%), bathing instructions were provided. • In 12 of 12 (100%) PNMPs, toileting-related instructions were provided, including check and change. • In 12 of 12 (100%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. Each of the others was described as independent. • In 12 of 12 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. • Four individuals (100%) had feeding tubes with limited to no oral intake. Four of four (100%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. • In 12 of 12 PNMPs/dining plans (100%), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. • In 8 of 8 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. • In 8 of 8 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. • In 8 of 8 PNMPs/dining plans for individuals who ate orally (100%), dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular equipment, and the rationale was provided. • In 12 of 12 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. • In eight of 12 PNMPs (67%), oral hygiene instructions were included, including general positioning and brushing instructions. Individual #60's PNMP simply stated for staff to assist with Oral care but provided no further instruction. Missing completely from the PNMPs was information regarding positioning when the individual went for a dental appointment. Failure to provide positioning requirements for dental may place the individual at risk for increased aspiration. • 12 of 12 PNMPs (100%) included information related to communication (how individual communicated, how staff should communicate with individual). Missing from the communication section was detailed information on how the	

#	Provision	Assessment of Status	Compliance
		person communicated as well as how staff should bridge communication. <u>Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT</u> For 6 individuals in Samples O.1 and O.2 for whom the IDT identified changes needed to be made to the PNMP, ISPA meeting documentation noted for two (33%) that the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. For example: Individuals #40, #35, and #143 had risk levels that needed to be updated based on the IRRF or IDT discussion but this was not evident on the PNMP. For two individuals for whom the PNMP was revised, there was supporting documentation that two of two revised PNMPs (100%) had been implemented. For one of four Individuals (25%) from Sample O.5 who had a downgrade in diet texture, there was evidence it was discussed as part of a ISPA by the IDT in response to change in status.	
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.	<u>Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs</u> Three mealtime observations (2 lunches and 1 dinner) 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. Per observations conducted by the Monitoring Team, seven of 15 individuals' (46%) dining plans were implemented as written. Examples included: • Individual #101 was observed taking multiple bites without swallowing when staff walked away during the meal • Individual #36 was observed hyper-extending and coughing during meal.. Although the implementation has declined since the last visit (61% to 46%) the mealtime overall was much calmer and had improved staff interaction. Based on observations by the Monitoring Team: • Eight of eight positioning plans for individuals' for Sample O.1 (100%) were implemented as written. • Three of three individuals' transfer plans (100%) were implemented as written. • As reported in Provision M6, a nurse administering medications appropriately and immediately completed a focus assessment according to the Aspiration Protocol when an individual hyperextended her neck and coughed. <u>Knowledge of Staff Regarding PNMPs</u> Staff Interview: Staff were increasingly knowledgeable of the Individuals' PNMPs. Based upon interviews with six staff from La Paloma and El Paisano, knowledge of staff has	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>continued to improve. Following are the numbers of staff who answered correctly and the number asked the question:

<table>
<tr><th></th><th># Asked</th><th># Correct</th><th>% Correct</th></tr>
<tr><td>Positioning:</td><td></td><td></td><td></td></tr>
<tr><td>How do you know the individual is in the correct position in their wheelchair/bed?</td><td>4</td><td>4</td><td>100%</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Mealtimes:</td><td></td><td></td><td></td></tr>
<tr><td>For what reason does the individual have thickened liquids?</td><td>4</td><td>3</td><td>75%</td></tr>
<tr><td>For what reason does the individual eat a modified texture?</td><td>6</td><td>5</td><td>83%</td></tr>
<tr><td>What is the reason for the individual using a specific utensil?</td><td>6</td><td>4</td><td>67%</td></tr>
<tr><td>If the individual receives enteral nutrition, how do you determine if he/she is in the correct position?</td><td>4</td><td>4</td><td>100%</td></tr>
</table></td><td></td></tr>
<tr><td>O5</td><td>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.</td><td><u>NEO Orientation</u>
The PNM related core competencies (i.e., foundational skills) were comprehensive. New employee orientation (NEO) included the following elements:
• Lifting and Transfers;
• Positioning (Alternate, wheelchair, and bathing/showering);
• Adaptive Equipment;
• PNMP orientation and implementation;
• Safe Mealtime strategies; and
• Basics of Dysphagia.

The above components were included as part of the four following classes:
• Lifting People
• Physical and Nutritional Management
• Dining Dos and Don’ts
• Speech Training

Sixteen of 16 new employees (100%) successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs since the last onsite review.

<u>PNM Core Competencies for Current Staff</u></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		The Facility, while collecting data on individuals who had been trained on Lifting, PNMPs and Preventing Aspiration, did not a system in place in which they could utilize the acquired data in a way that provided useful information regarding what trainings had been completed by staff and what trainings were still required. Based upon review, in order to obtain this information, the Facility would have to hand tally the trainings completed staff by staff. Due to this, the Monitoring Team was unable to determine if all staff had received the appropriate training. Two of 2 staff (100%) responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. These staff included those who were responsible for training the following courses: • Lifting People • Physical and Nutritional Management • Preventing Aspiration <u>Annual Refresher Training</u> The Facility was unable to provide information regarding the number of staff who were expected and who had completed annual refresher trainings related to Physical and Nutritional Supports; therefore the Monitoring Team was unable to if staff were adequately maintaining their level of training and education. <u>Individual-Specific Training</u> To determine whether the Facility had a process to determine whether staff had been trained on components of PNMPs for individuals they supported, the Monitoring Team requested evidence that all assigned staff for Individuals #40, #108, and #35 in Sample O.1 had received training on the latest revision to their PNMP. For Individuals #35, #40, and #108, 142 of 170 (83%) staff assigned had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills). The concern noted was that there was no evidence of what date the individual was trained; therefore, the Monitoring Team was unable to determine if staff had been trained prior to the provision of services. Staff responsible for training other staff did successfully complete competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. The Facility did have a process to validate that staff responsible for training other staff are competent to assess other staff's competency.	

#	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.	<u>Facility's System for Monitoring of Staff Competency with PNMPs</u> Monitoring tools included adequate indicators to determine whether or not "staff demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. As stated in previous reports, 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. Monitoring tools did include adequate instructions. RGSC had developed a Compliance Monitoring Form guiding questions sheet regarding what the staff conducting the monitoring should be considering and looking for as well as how training should be provided in the occurrence a deficiency was noted. Staff members had completed all the requirements to demonstrate competence in monitoring. Members of the PNMT were primarily responsible for the majority of monitors completed at RGSC. There was evidence that members responsible for monitoring: 1. Completed the necessary core training related to PNM. 2. Were trained on Individual specific strategies. **3.** Successfully completed training on the monitoring forms. Based on review of monitoring completed between 1/3/13 to 5/6/12, the PNMP monitoring process did not cover all areas that were likely to provoke swallowing difficulties or increase pnm risk, based on the following: • 44 % of the monitoring forms focused on oral intake (meals and snacks) • 4 % of the monitoring forms focused on bathing • 16 % of the monitoring forms focused on medication administration • 6 % of the monitoring forms focused on Oral Care. • 14% of the monitoring forms focused on positioning • 16% of the monitoring forms focused on lifting/transfers • 76 % occurred during first shift • 24 % occurred during second shift • 0 % occurred during third shift Although the number of meal monitors occurred at a higher frequency, it was felt to be proportionate to the issues facing the individuals at RGSC. The issue noted was that the monitors were not completed across all three shifts.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Monitoring for Individuals in Samples For individuals in Sample O.1, PNM compliance monitoring over the past three months for seven of ten individuals (70%), the frequency of monitoring occurred as per the individuals' assessment and/or the individuals' plans/IHCPs. For individuals in Sample O.2, PNM compliance monitoring over the past three months for two of two individuals (100%), the frequency of monitoring occurred as per the individuals' PNMT assessment and/or the individuals' plans/IHCPs. Frequency of monitoring primarily defaulted to the risk based monitoring schedule which was as follows: 1. High Risk: 2x monthly/ 24 year 2. Medium Risk: 1.5x monthly/18 year 3. Low Risk: 1x monthly /12 year The problem with the monitoring process was that there were not clear criteria identified as to what placed in the Individual in a specific risk category. Per interview with PNMT Chairperson, the risk levels were based on 2012 risk levels. This criterion was not memorialized in the process and did not reflect current risk status. Failure to have monitoring based on current risk levels increases the likelihood of those at the highest level of risk not receiving the monitoring needed. This was evident with Individuals #35 and #108 who were both high risk but were monitored at the medium risk level since this was their level last year.	
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.	IDT and PNMT Monitoring to Assess Individual's Progress and/or Effectiveness of the Plans Zero of the 12 individuals' records in Samples O.1 and O.2 (0%) contained evidence of indicators integrated as part of the IHCPs to assess the individual's PNM status. The IHCP did not contain criteria for referral to the PNMT, Nursing or other related services (i.e., Habilitation Therapy). Zero of the 12 individuals' records in Samples O.1 and O.2 (0%) contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans was monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans, IPNs and data from the PNM related monitoring forms. QDDP monthly reviews provided no information regarding status of the individual or if the individual had any issues related to PNM or if the plan had been revised over the past month. Two of 12 individuals' records (16%) in Samples O.1 and O.2 included evidence that the	Noncompliance

#	Provision	Assessment of Status	Compliance
		team discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual. Trigger sheets were reviewed for the 12 Individuals in Sample O.1 and O.2 for the past three months. This totaled a review of 36 trigger sheets. Two of 36 Trigger sheets (5%) were completed correctly. Thirty-six of 36 Trigger sheets (100%) were reviewed at a minimum daily by the RN but not consistently every shift as directed. Zero of 36 Trigger sheets (0%) included individualized triggers as indicated. For example: Individual # 143's trigger sheet included a trigger for formula in the mouth although the individual was not tube fed. Issues with the Aspiration Trigger Sheet included: 1. The trigger sheet contained multiple gaps in data due to lack of completion. • Triggers when occurred were not consistently documented on the trigger sheet. • Nursing and Case Manager review of the trigger sheet was inconsistent. Another concern noted was consistent response to triggers. For example: Individual #19 who has had recent aspiration pneumonias had ten coughing episodes on 2/24/13 but there was no evidence of nursing notification or assessment.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>Evaluation of Individuals who receive Enteral Nutrition</u> The Facility had a sustainable system to maintain and update a list of individuals who were enterally fed. Included as part of the list was the individual's home, name, type of feeding, date tube was placed, diet, and if the individual received any form of pleasure feeding. Four of 4 individuals who receive enteral nutrition (100%) were evaluated at a minimum annually as evidenced by review of their IRRF, ISP, APEN and Nutritional Assessment. Four of four individuals (100%) evaluated had an appropriate evaluation to determine the medical necessity of the tube. Medical necessity was identified as part of the Nutritional Assessment, Habilitation Assessment, as well as part of the APEN when present. A concern noted was that information regarding medically necessity was inconsistent in its locations and not readily present as part of the IRRF.	Noncompliance

#	Provision	Assessment of Status	Compliance
		No individuals who received enteral nourishment were admitted since the last review; therefore, the Monitoring Team was unable to review if the medical necessity of the feeding tube was assessed within 30 days. <u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u> Four of four individuals (100%) from Sample O.3 who receive enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. One individual (Individual #19) was identified as potentially benefitting from oral motor treatment. Plans for returning to oral intake had not yet been developed and therefore the Monitoring Team was not able to determine if the plans included all of the following components: o Staff training required prior to implementation; o Staff roles and responsibilities (e.g., implementation, monitoring); o Time and schedule of interventions; o Specific triggers for when the plan should be stopped; o Milestones for progressing with the plan; o Documentation requirements (method for tracking progress); and o Frequency of subsequent assessments and staff responsible. The Monitoring Team was unable to determine if the plan for returning to oral eating was based on the results of the IDT's discussion and was integrated in the IHCP, ISP, and/or an ISPA since the plan had not yet been developed at the time of the review. The IRRF did not provide clinical assessment data to identify an individual's potential to return to oral eating. IRRFs did not provide justification for the medical necessity of the feeding tube. Additionally, any plan the IDT develops should be memorialized in an IHCP that is part of the ISP, and/or documented in an ISPA. No individuals were provided with clear plans to return to oral intake and therefore the Monitoring Team was unable to determine: • Whether plans were implemented in a timely manner • If staff responsible for implementation of these oral intake plans were competent to do so through competency-based training conducted by a licensed clinician with specialized training in PNM.	

#	Provision	Assessment of Status	Compliance
		• If plans were monitored as outline in the plan • If plans were modified as needed by the IDT	

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

1. The PNMT policy should be revised to include the following components:
   - Method for establishing triggers/thresholds;
   - Evaluation process for individuals who are enterally fed;
   - Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia;
   - Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor,
   - Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician. (Provision O.1)
2. RGSC must have available an OT who can serve as a core member of the PNMT on a consistent basis. (Provision O.2)
3. The PNMT evaluation should contain review of all areas of care for potential impact of the identified PNM issue (Provision O.2)
4. PNMPs should contain information regarding positioning when the individual requires a dental appointment. (Provision O.3)
5. The IDT should meet in response to changes in status to ensure all members are aware of changes and how they impact the overall level of care. (Provision O.3)
6. The Facility should develop a system that provides information regarding the number of staff who are expected to complete and who had completed annual refresher trainings related to Physical and Nutritional Supports. (Provision O.5)
7. The Facility should ensure that there is a method for documenting not only if staff were trained on Individual specific interventions but when they were trained so that the Facility may ensure only staff who had been trained work with "at risk" Individuals. (Provision O.5)
8. Monitoring should cover all areas and occur on all shifts, as the risk of aspiration and other PNM related issues is not limited to day shifts. (Provision O.6)
9. Indicators should be integrated as part of the IHCPs to assess the individual's PNM status. The IHCP should contain criteria for referral to the PNMT, Nursing or other related services (Provision O.7)
10. Trigger sheets should be consistently and correctly completed and be individualized to the person in which they are being used. (Provision O.7)

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:	**Documents Reviewed:** 1. RGSC Self-Assessment, dated 4/29/13 2. RGSC Action Plan 4/25/13 3. PNMP Policy (rev 4-2013-draft) 4. RGSC Policy 500-02 Occupational and Physical Therapy Services (rev: 8/2012) Record reviews: 5. Sample P.1: Individuals #19, #35, #40, #47, #60, #79, #108, #114, #115, #126, #139 and #143 6. Sample P.2: Individuals #5, #27, #63, and #140 7. Sample P.3: Individuals #15, #40, #114, and #140 8. Lists of individuals: a. Who cannot feed himself or herself and notation of any changes since the last review; b. Who require positioning assistance associated with swallowing activities and notation of any changes since the last review; c. Who have difficulty swallowing and notation of any changes since the last review; d. At high and/or medium risk for aspiration pneumonia and choking; e. With choking incidents since the last compliance review f. Who had a feeding tube inserted since the last compliance review g. Who were admitted to the hospital since the last compliance visit with admitting and discharge date and diagnosis h. Who were diagnosed with pneumonia or a respiratory difficulty since the last compliance review (include date and type) i. With falls in the last 12 months (date, location, type of injury)* j. With chronic respiratory infections k. With chronic dehydration l. With fecal impaction m. With pressure ulcers in the last 12 months (date, location and resolution) n. With fractures in the last year (date, location of fracture, status) o. Who were non-ambulatory or require assisted ambulation p. With wheelchairs for primary mobility q. With wheelchairs for transport r. Who use Assistive Devices for ambulation (type of device) s. With orthotic/braces 9. New PNMT members since last review, including a copy of their curriculum vita; 10. Caseloads of PNMT dedicated and non-dedicated members. 11. List of medical consultants to the PNMT (e.g., medical doctor, nurse practitioner, or physician's assistant) and PNMT meeting minutes and attendance sheets for presence and participation of a medical doctor, nurse practitioner or physician assistant, and other IDT members as needed or defined in Facility policy.

	12. PNMT members and PNMT back up members curriculum vitas 13. QA reports/matrix since the last compliance review 14. List of referrals to the PNMT since the last compliance visit 15. PNMT RN post hospitalization assessments completed since the last compliance visit. 16. PNMT assessment template 17. PNMT Action Plan template 18. Habilitation Therapy Annual Assessment 19. Habilitation Therapy Update 20. Wheelchair/Adaptive Equipment Maintenance Log (last 6 months) 21. IRRF template 22. IHCP template 23. List of new employees since last compliance visit and their PNM related performance check offs 24. PNM Monitoring Tool template 25. Last three months of PNM monitoring data (including date, activity monitored, time of monitor, person conducting monitor) 26. For Individuals in Samples P.1 and P.2: t. All ISPs in the last 12 months u. All ISPAs in the last 12 months v. All IRRFs in the last 12 months w. All IRRF Action Plans in the last 12 months x. IHCP/Action Plan y. QDDP Monthly Reviews for the last 6 months z. PBSPs aa. Braden Scale forms bb. Annual weight graph cc. Nutrition tab, including assessments and reviews dd. HOBE assessments ee. PNMT assessments and any other PNMT documentation other than IPNs in the last 12 months, if not already submitted ff. OT/PT assessments in the last 12 months gg. Six months IPNs hh. Trigger sheets completed in the last 6 months, including the current one ii. PNMPs in the last 12 months, including pictures jj. Dining Plans in the last 12 months, including pictures kk. Completed PNM-related monitoring sheets in the last three months ll. Evidence of effectiveness monitoring completed within the last six months mm. APEN in the last 6 months nn. Plan for individuals who are returning to oral eating and supporting documentation for implementation of plan (i.e, staff training documentation, staff roles and responsibilities, specific triggers when the plan should be stopped; milestones for progress with the plan, documentation requirements to track progress, and frequency of subsequent assessments and staff responsible and monthly progress notes)

	oo. Direct intervention plan and supporting documentation for implementation of the plan (e.g., monthly progress notes) pp. Individual notebooks (PNM section) **People Interviewed:** 1. Jane Augustine PT Director of Habilitation Services 2. Pamela Hawxhurst OTR 3. Betty Perez Rehab Tech II **Meeting Attended/Observations:** 1. PNMT meeting 5/14/13 2. Morning Medical 5/16/13 3. Mealtimes and Transitions (La Paloma, El Paisano)
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 4/29/13, and Action Plan dated 4/25/13. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section P, in conducting its self-assessment, the Facility: • Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section P. o This monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. For example, the Self Assessment for Provision P.1 did not include timeliness of assessments. o The monitoring tools did include adequate methodologies, such as observations, record review and staff interview. For example, the Settlement Agreement Monitoring Tool guidelines instructed the reviewer to review the OT/PT assessment, and review of SAPS for proper integration. o The Self-Assessment did not identify the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). o The Self-Assessment did not state the following staff/positions who were responsible for completing the audit tools such as Facility therapists (i.e., OTs, PTs, and SLPs); therefore there was no evidence staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools. • The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not consistently measure of the quality as well as presence of items.

	o Did not distinguish data collected by the QA Department versus the program/discipline. • The Facility rated itself as not being in compliance with any of the provisions of Section O. This was consistent with the Monitoring Team's findings. The Actions plans developed were felt to move RGSC in the right direction towards compliance; however, RGSC should continue to review the findings of the Monitor's report and revise the Action Plans as indicated to address all identified concerns. Methods to gauge quality and not just presence should be investigated and integrated as part of the Action Plan.
	Summary of Monitor's Assessment: Overall, improvement was noted with the comprehensiveness of the OT/PT assessments as well as with staff implementation of the PNMPs. Improvement with the OT/PT policy needs to occur so that it clearly provides the detail needed to ensure consistent supports are in place and the team responds to changes in status in a timely manner. 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. Additionally, the policies/procedures were missing elements that clearly identified the monitoring process and there was no evidence that staff or the individual was monitored across all three shifts. **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. **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 restorative care, the primary support provided was via the PNMPs. Additionally, therapy services were not consistently integrated into the ISP. There was little justification as to why it was felt that the individuals would benefit from many of the OT/PT programs and what was the clear measurable objective to determine efficacy of treatment. **Provision P.3:** This provision was determined to be not in compliance. The Facility was unable to provide information regarding the number of staff who were expected and who had completed annual refresher trainings related to Physical and Nutritional Supports; therefore. the Monitoring Team was unable to determine if staff were adequately maintaining their level of training and education. Additionally, there was no evidence of what date the staff was trained regarding individual specific training; therefore, the Monitoring Team was unable to determine if staff had been trained prior to the

	provision of services. **Provision P.4:** This provision was determined to be not in compliance. The Monitoring Team was unable to assess if repair of adaptive equipment was completed within 30 days unless justification was provided and, in cases where health and safety was impacted, whether the equipment was repaired within 48 hours.

#	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.	Samples for this section were as follows: Sample P.1 is the same as Sample O.1 that consisted of a non-random sample of 12 individuals who were chosen from a list provided by the Facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis], require mealtime assistance and/or are prescribed in a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Sample P.2 consisted of four individuals who received restorative care. These individuals were chosen due to RGSC not having any individuals at the time of the review receiving direct treatment. Sample P.3 consisted of four individuals who had experienced a high number of falls over the past 6 months. <u>Timeliness of Assessments</u> Two of two admitted individuals since the last review (100%) received an OT/PT screening or assessment within 30 days of admission or readmission. Two of two individuals (100%) identified with therapy needs received a comprehensive OT/PT assessment within 30 days of identification. RGSC's policy states that assessments will be provided in place of screenings upon admission; therefore, the Monitoring Team included the presence of assessments as meeting and surpassing compliance with this metric. Two of 10 individuals' OT/PT assessments in sample P.1 (20%) were dated as having been completed at least 10 days prior to the annual ISP. Habilitation Assessments were not consistently completed in a timely manner and therefore were unavailable for	Noncompliance

#	Provision	Assessment of Status	Compliance
		review by the IDT prior to the ISP. The lack of having this information available greatly impacts the ability to have a thorough and meaningful discussion by all team members as part of the ISP process. In a few of the cases, the Monitoring Team was unable to determine if the assessment was completed as the ISP was not updated or completed per facility policy. Two of 12 assessments or updates in Sample P.1 (16%) were current within 12 months for individuals who are provided PNM supports and services. Zero of four individuals (Sample P.3) (0%) who experienced falls were appropriately reviewed by the IDT. Individuals who experienced multiple falls did not have evidence of team discussion regarding the situation in which the falls occurred and factors potentially impacting the occurrence. For example: • Individual #40 fell eight times which was more than anyone else at RGSC yet there was no evidence of discussion to address incidents. • Individual #140 fell seven times before there was evidence of the IDT meeting. • Individual #114 fell five times but the team did not meet to discuss the falls until the quarterly meeting in March 2013. <u>OT/PT Assessment</u> Metric: Based on review of the sample of assessments, the comprehensiveness of the OT/PT assessments for samples P.1 were as follows: • Copies provided by RGSC were not of the originals; therefore, the Monitoring Team was unable to determine if the individuals' OT/PT assessments were signed and dated by the clinician upon completion of the written report. • Twelve of 12 assessments (100%) included diagnoses and relevance to functional status. • Twelve of 12 assessments (100%) 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. • Nine of 12 assessments (75%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous years or assessments. • Ten of 12 individuals' OT/PT assessments (83%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. • Twelve of 12 assessments (100%) included medical history and relevance to	

#	Provision	Assessment of Status	Compliance
		functional status. • Twelve of 12 assessments (100%) addressed health status over the last year. • Twelve of 12 assessments (100%) listed medications and potential side effects relevant to functional status. • Twelve of 12 assessments (100%) included documentation of how the individual's risk levels impact their performance of functional skills. • Twelve of 12 assessments (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). • Twelve of 12 assessments (100%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. • Zero of 12 assessments (0%) included discussion of the expansion of the individual's current abilities. • Zero of 12 assessments (0%) included discussion of the individual's potential to develop new functional skills. • Zero of 12 assessments (0%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. • Ten of 12 assessments (83%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs. • Six of 12 assessments (50%) included a monitoring schedule. The monitoring schedule primarily listed was the default schedule that is based upon risk. • Twelve of 12 assessments (100%) included a re-assessment schedule. The reassessment schedule at RGSC was an updated every year if receiving direct or indirect services. • Twelve of 12 individuals' OT/PT assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This information was much improved as more detailed requirements were now included as part of the overall determination. • Nine of 12 assessments (75%) provided a statement regarding "Factors for Community Placement" that is detailed and lays out the supportive services needed for successful living. • Copies provided by RGSC were not of the originals; therefore, the Monitoring Team was unable to determine if assessments included evidence that communication and or collaboration was present in the OT/PT assessments as evidenced by dated signature. • Zero of 12 assessments (0%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This information was primarily contained within the PNMP.	

#	Provision	Assessment of Status	Compliance
		The Monitoring Team noted an issue specific to cerebral palsy (CP). Individuals #19, #51, #85, #91, #118 and #143 were reviewed regarding proper management of cerebral palsy. Based on the review : 1. Two out of six (33%) PT/OT assessment documented a clinically appropriate assessment of the individual's CP. 2. Zero out of six (0%) were periodically followed throughout the monitoring period by the PT/OT for CP. 3. For additional information see Provision L.1 "Management of Cerebral Palsy."	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	<u>OT/PT Interventions</u> For individuals receiving OT/PT supports and services, 12 of 12 plans for Samples P.1 and P.2 (100%) were developed within 30 days of the date of the assessment/update, or sooner as indicated by need. For two of ten individuals in Sample P.1 (20%), the ISP/ISPAs addressed each of the recommendations outlined in the current OT/PT assessment. Many times there was potentially lack of integration of the Habilitation Assessment into the ISP due to the assessment being late. <u>Direct OT/PT Interventions</u> RGSC was not providing direct services. Per conversation with the Facility OT, this was an area that the Facility was aware of and they were in the process of developing areas within Vocational Education in which direct as well as indirect services could be provided. Four rooms were in the process of being developed that would focus on gross motor, fine motor and visual perceptual, activities of daily living (ADLs), and sensory. In addition to the direct treatment, documentation should be in place that ensures all programs are measurable and functional to the individual. Additionally, the assessments should include progress made with each assigned program. As of this review, there was no evidence that OT/PT staff were proactively reviewing plans of care or providing treatment aimed at minimizing skeletal deformities or changes in status of skeletal structure as it relates to diagnoses such as Cerebral Palsy. Until this is implemented, the Monitoring Team reviewed the restorative program to capture data regarding direct intervention. The records of individuals in Sample P.2 were reviewed resulting in the following findings: • Four of four individuals' intervention plans (100%) were implemented within	Noncompliance

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		30 days of the plan's creation, or sooner as required by the individuals' health or safety. • For four of four individuals' records (100%) reviewed, the current OT/PT assessment identified the need for direct intervention with rationale. These could be annual assessments or interim assessments completed during the year in response to changes in status or identified needs. • For zero of four individuals' records (0%) reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. Measurable outcomes were not included as part of the ISP or ISPA but were clearly included as part of the OT/PT plan of service. • For zero of four individuals' records (0%), whose therapies had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. Clinical justification for the termination of a direct intervention plan was not included as part of the discharge/final note. Another problem identified was that there was no consistent ISPA meeting upon discharge to discuss final results and recommendations. <u>Indirect OT/PT Programs</u> The implementation of these plans is also discussed under Section O4 for PNMPs and in Section S for skill acquisition plans. The use of Sensory Diets/programs had increased considerably since the previous compliance visit and was the primary method of OT/PT skill acquisition plans (SAPs). The concern was that there was little justification as to why it was felt that the individuals would benefit from these programs and what was the clear measurable objective to determine efficacy of treatment. At the time of the review, the primary objective was to improve mind-body organization but little to no information was beyond provided that statement regarding how the program would impact the individual and how it would be measured. Five individuals from Sample P.1 were receiving such a sensory diet. Per review, zero of five (0%) had a clear review or analysis of data in which determinations were made by the QDDP or therapist regarding progress. <u>Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP</u> An OT or PT attended the ISP or ISPA meeting, unless adequate justification was provided in the Pre-ISP meeting documentation. Ten of 10 ISP annual meetings (100%) had a member from either OT or PT present to represent the disciplines. Two of 10 ISPs or ISPAs in sample P.1 (20%) clearly integrated the OT/PT	

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		interventions. The ISP or ISPA did not consistently describe the supports based on the rationale provided in the therapy assessment. Many ISPs simply stated that the individual had a PNMP and the IDT approved it. In one of seven of the ISPs or ISPAs reviewed (14%), skill acquisition programs that had been recommended in the OT/PT assessment were present. The problem noted with this area was that skill acquisition programs continued to be rarely identified as part of the Habilitation Assessment. The Habilitation Assessments continued to focus primarily on supports to mitigate risk or provide support and did not identify potential areas in which skills such as ADLs could be addressed. For two of seven individuals from Sample P.1 (28%), the ISP/ISPAs contained measurable objectives related to functional individual outcomes. Measurable outcomes were not consistently included as part of the ISP or ISPA. Zero of four individuals receiving direct/restorative OT/PT Services (0%) were provided with comprehensive progress notes (IPNs) that contained each of the indicators listed below. o Contained information regarding whether the individual showed progress with the stated goal including clinical data to substantiate progress and/or lack of progress with the therapy goal(s). o Described the benefit of the goal to the individual. Although this indicator was not present as part of every note entry, it was observed as part of the initial as well as discharge/final note and therefore meets the intent of this indicator. o Reported the consistency of implementation. o Identified recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress. o A comprehensive progress note was completed on at least a monthly basis. For individuals with PNMPs or SAPs focused on indirect services, for 0 of 12 individuals from Samples P.1 and P.2 (0%), there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. Monthly documentation from the OT and PT and/or QDDP did not include: • Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); • A description of the benefit of the program; • Identification of the consistency of implementation; and • Recommendations/revisions to the indirect intervention and/or program as	

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		indicated in reference to the individual's progress or lack of progress. The monthly QDDP did not reference the PNMP or OT/PT-related SAPs. No detail regarding the implementation of the services, the effectiveness, or the need to revisit identified concerns was contained within the monthly review.	
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.	The requirements for this section were discussed in detail with regard to Section O.5. Criterion: Substantial compliance with Provision O.5.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	<u>Monitoring System</u> The Facility did not implement a system for the adequate monitoring of PNMPs. • See Provision O.6 The Facility did not have a comprehensive OT/PT policy. The policy included the following elements: • Description of the role and responsibilities of OT/PT; • Defines the monitoring process for the status of individuals with identified occupational and physical therapy needs; • Defines how individuals' OT/PT needs will be identified and reviewed; and • Sets forth documentation expectations for individuals receiving direct services Missing from policies/procedures reviewed were elements that: • Define the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; • Include re-evaluation of monitors on an annual basis by therapists and/or assistants; • Describe referral process and entrance criteria; • Define a formal schedule for monitoring to occur; • Identify the frequency of assessments; • Identify monitors and their roles and responsibilities; • Include monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; • Require that results of monitoring activities in which deficiencies are noted are	Noncompliance

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		formally shared for appropriate follow-up by the relevant supervisor; • Require statement of discharge criteria; • Define a formal schedule for monitoring to occur. These areas are related to issues noted earlier in Section P.2 regarding lack of monthly review of services. For ten of ten individuals in Sample P.1 (100%), routine maintenance checks were conducted to ensure that positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. Monitoring data logs provided to the Monitoring Team indicated checks of positioning devices and other adaptive equipment were included as part of the risk based PNMP monitoring. The Monitoring Team was unable to assess if repair of adaptive equipment was completed within 30 days unless justification was provided and, in cases where health and safety was impacted, whether the equipment was repaired within 48 hours. At the time of the review, the adaptive equipment checklist provided to the Monitoring Team identified when the equipment was submitted for repair and when it was repaired, but it did not include the date the equipment was found in need of repair and notice of need was given. Per interview with the Director of Habilitation Services, submission date was not always the same as the date the equipment was noted to be in need of repair. Therefore timeliness of repair could not be reviewed.	

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

1. Habilitation Assessments must be completed and submitted ten days prior to the annual ISP planning meeting. (Provision P.1)
2. The ISP/ISPAs must do a better job of identifying functional gains resulting from provided therapies. (Provision P.2)
3. ISPAs should be provided when an individual is discharged from therapy to allow for review of status and determination of whether additional interventions are warranted. (Provision P.2)
4. Monthly documentation from the OT and PT and/or QDDP should include:
   - Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s);
   - A description of the benefit of the program;
   - Identification of the consistency of implementation; and
   - Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. (Provision P.2)
5. The maintenance log for wheelchair/adaptive equipment repair should include the referral date in addition to the repair date so that RGSC may track the timeliness in which repairs are provided in response to identified concerns. (Provision P.4)
6. Documentation standards and expectations regarding monthly review of indirect OT/OT (PNMP) supports should be included as part of the facility policy. (Provision P.4)

7. A system must be implemented that ensures all staff (all shifts) are monitored for implementation of indirect OT/PT services (PNMPs). (Provision P.3)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Action Plan, 4/25/2013 2. RCSC Self-Assessment, 4/29/2013 3. RGSC Presentation Book, 5/2013 4. RGSC Policy: Services Manual, Standard Operating Procedure, ICF-IID 700 03: Individual Care Activities, dated September 1992. 5. RGSC Policy: Standard Operating Procedure ICF-IID 400 16: Pre-Medication for Medical and Dental Procedures, Revised August 2012 6. List of oral health care professionals who provide service to the Facility 7. List of all individuals who were assessed for suction toothbrushing 8. List of all individuals provided suction toothbrushing 9. List of all individuals provided general anesthesia in past 12 months 10. List of all individuals who are pending general anesthesia 11. List of all individuals who were not current with dental evaluations and treatments 12. Copy of dental schedule for past 12 months 13. List of individuals who were current and not current with dental x-rays (current dental log) 14. Dental records, associated ISP documentation, and IPNs for Individuals #31, #55, #72, #115, #27, #51, #4, #48, #141, and #93 **People Interviewed:** 1. Mario Menchasca, RDH 2. Lorraine Hinrichs (ICF- DD Director) **Meeting Attended/Observations:** 1. None
	Facility Self-Assessment: The Monitoring Team was impressed the Facility's had begun the use of data for its self-assessment, and concurs with the Facility's assessment of noncompliance with Provisions Q.1, and Q.2 of the Settlement agreement. The Monitoring Team agrees with the specific items that were selected for the self-assessment, however, recommends that the document, or process used to determine compliance is documented. For example, the Facility used the term "review of data indicates", and the Monitoring Team recommends the Facility to include the specific data elements that were reviewed. Also, it was noted that the Facility had not assessed if standard of care practice was provided, or if an action was actually completed. For example, the Facility rated itself as providing preventive care to 85% of individuals; however, the Monitoring Team noted that, although the dentist saw many individuals more than one time per year, there was no documentation that any individual was provided dental hygiene services more than one time per year. Standard of care practice supports that Individuals be provided dental hygiene at least twice per year. Also, the Facility indicated that IPNs complemented dental progress notes (DPNs); however, the integrated progress note (IPN) is suppose to be differentiated by the DPN by

	being written in language that can be understood by non-dental professional staff. The Monitoring Team could not identify IPNs developed in such a way. Of significant concern is that the facility reported, as a positive, as not having provided TIVA, or pre-treatment sedation to individuals; however, there were a number of individuals who were not provided timely oral health care services because they were not provided appropriate levels of anxiolytics, and/or sedation. With regard to the action plan, the Facility was not specific and did not delineate an action plan for each step necessary to achieve substantial compliance. For example, the Facility listed broad action steps, such as "ensure that the facility has the necessary resources to provide adequate oral care to all individuals". The Facility should identify what specific issues, and associated resources are necessary for providing adequate oral care. Another example is the action step "Develop and implement a mechanism for those individuals that require suction tooth brushing". Again, the Facility should delineate what steps are necessary to accomplish this action plan.
	Summary of Monitor's Assessment: The Facility did not maintain a dental office; therefore, oral health care assessments and treatments were provided by community dentists, or at the local hospital. The Facility is, however, responsible to ensure that all necessary treatments, evaluations, and oral hygiene are provided as clinically needed, and per standard of care practice. The Monitoring Team noted little meaningful progress since the last reporting period, and strongly encourages the Facility to assertively address Provisions Q.1, and Q.2, of the Settlement Agreement. Following is a summary of the Monitoring Team's more significant concerns for Section Q: **Provision Q.1:** The Monitoring Team determined that the Facility is not in compliance with Provision Q.1, of the Settlement Agreement because annual dental evaluations were not completed timely, there was no formal process to assess individuals who experience a functional change that would result in the need for suction toothbrushing, and there was no formal mechanism to assess the efficacy of suction toothbrushing program. Also, there was no policy or procedure for dental emergencies. **Provision Q.2:** The Monitoring Team determined that the Facility was not in compliance with Provision Q.2 of the Settlement Agreement. The Facility must develop and implement a quality assurance process to assess the efficacy, and potential adverse outcomes, for dental services; develop and implement a clinically sound approach to providing sedation for dental treatments; enhance the frequency of its dental rehearsal program; and improve on tracking and trending system issues related to missed dental appointments.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30	To assess the Facility's ability to provide standard of care oral health care, the Monitoring Team assessed dental administration, the annual dental evaluations, emergency dental process; dental and oral hygiene, and the Facility's suction toothbrush program.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	<u>Dental Administration</u> To assess Dental administration, the Monitoring Team discussed dental administration with Mario Menchasca and Lorraine Hinrichs, and requested a list of all providers of dental care. The Facility did not maintain a dental treatment office; therefore, individuals were transported for service to dental offices in the community, or the local hospital. The Facility contracted with a part time dental hygienist, who provides service one day per week at the Facility. The Hygienist oversees oral health care at the Facility, and runs the Facility's dental rehearsal program, which was designed to help reduce the individuals' reliance on sedation for dental treatments. Designated support staff are responsible to maintain the dental appointment and follow-up schedule. <u>Annual Dental Evaluations</u> To assess the provision of dental services, representation of dental services in the context of the individual support plan (ISP), and documentation of dental services in the clinical record, the Monitoring Team requested the dental records, associated ISP documentation, and IPNs for the first ten individuals on the name key. Only nine examples were provided for review (Individuals #31, #55, #72, #115, #27, #51, #4, #48, #141, and #93): • Five out of nine (55%) of the Individuals were provided an annual dental examination within the past 365 days. • A periodontal and dental rating was documented for three out of the nine cases (33%). • Of the three cases that documented periodontal ratings, three out of three (100%) had mild periodontal disease, and required enhanced oral health. • The ISP of zero out of nine (0%) cases adequately documented the individual's oral health condition, prognosis of oral health issues, how the individual's oral health condition affects the individual, and all necessary supports and services for the management of oral health issues; however, the ISP for Individual #31 did provide a more comprehensive review of oral health care issues, when compared to other ISPs. • For the five cases evaluated by the dentist, zero out of five (0%) included an IPN that documented, in non-dental office staff language, the outcome of the dental evaluation. Summary: Based on the documents provided, the Monitoring Team determined that the Facility did not provide necessary and adequate dental services to Individuals at the Facility, because	

#	Provision	Assessment of Status	Compliance
		only 55% of the individuals reviewed had a current annual dental evaluation. The Facility did not provide associated dental IPNs, when necessary, and the ISP process did not adequately document oral health care needs for individuals. Dental Emergencies To assess the Facility's ability to manage dental emergencies, the Monitoring Team requested a list of all dental emergencies that occurred during the reporting period; dental records, IPNs, and ISPs for the first ten individuals on the list; and the Facility's policy for dental emergencies. The Facility reported that it did not have a dental policy, and that no individuals experienced a dental emergency within the reporting period. Summary: Because there were no reported dental emergencies, the Monitoring Team could not assess the Facility's ability to manage dental emergencies. The Facility must develop a policy for the management of dental emergencies that reflects the Facilities practice. Dental Hygiene To assess the Facility's ability to provide dental hygiene, including regular examination, cleaning and additional care, as clinically indicated, the Monitoring Team requested dental hygiene records, and associated IPNs for the past 12 months. The Monitoring Team was provided with dental hygiene records for Individuals #29, #5, #97, #23, #113, #40, #31, #72, #48, and #93; however, only four of the samples (individuals #31, #72, #48, and #93) were part of the document request and were reviewed for this report. In zero out of four samples reviewed (0%), there was a Dental progress note and corresponding IPN that indicated that dental hygiene was provided, per standard of care practice. At a minimum, unless contraindicated, dental hygiene, which includes descaling, should be completed at least every six months. Summary: The sample did not include specific dental hygiene records, and an associated IPN, that documented dental hygiene. The Facility must ensure that dental hygiene is provided at level of dental standard of care (at least twice per year), unless contraindicated. Oral Care To assess oral health care at the living area, the Monitoring Team requested the oral health care plans for ten individuals; however, plans were provided for only nine of the ten individuals (Individuals #59, #19, #87, #122, #12, #76, #21, #113, and #5). The Monitoring Team also requested the Facility's policy and procedure for providing oral	

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		health at the living area. The Facility provided the Monitoring Team with a policy, entitled ICF-IID Services Manual, Standard Operating Procedure, ICF-IID 700 03: Individual Care Activities, dated September 1992. The Monitoring Team determined that the policy did not reflect all necessary all necessary components of an oral health care program. For the nine plans provided: • Eight out of the ten plans requested (80%) included a specific oral health plan, that was approved within the past 365 days. • Six out of the ten plans requested (60%) included documentation that oral hygiene was provided in April 2013 by direct care staff. • Eight out of ten plans requested (80%) included documentation that the hygienist assessed oral health within the past 365 days. Summary: Over all, the Monitoring Team determined that the Facility provided adequate oral hygiene. The Facility must update its policy on oral health care, to reflect the Facility's current practice. <u>Suction Toothbrushing</u> To assess the Facility's ability to develop and implement a suction toothbrushing process, the Monitoring Team requested policies and procedures for suction toothbrushing, a list of all individuals who were provided suction toothbrushing, and quality assurance data to demonstrate the efficacy of the Facility's suction toothbrushing process. The Facility reported that it did not have a suction toothbrushing policy or procedure; did not have a process to demonstrate the efficacy of suction toothbrushing; and did not have a specific policy, or procedure to guide the needs assessment for oral toothbrushing. The Monitoring Team provided a list of four individuals who are provided suction toothbrushing. Summary: The Facility must develop a process to ensure individuals are assessed, as clinically necessary, for the need of suction toothbrushing. The Facility must also develop a process to ensure periodic assessment of the suction toothbrushing process at the Facility.	

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		Log for Dental Radiographs The Monitoring Team was informed by Mario Menchasca and Lorraine Hinrichs that there was a specific log that tracked completion of dental radiographs for all individuals. Review of the dental log for radiographs, a total of 64 individuals were listed: • 54 out of 64 (84%) indicated that dental radiography was current. • Of the ten individuals identified as not being current: o Eight out of ten (80%) were delinquent because of challenging behaviors. o Two out of ten (20%) were delinquent because the individuals were hospitalized when radiography was scheduled. o In zero out of the ten delinquent cases (0%), a plan to obtain dental radiographs was documented Summary: Unless contraindicated, the Facility must ensure that dental radiographs are obtained when clinically necessary, and per standard of care practice. Conclusion The Monitoring Team determined that the Facility had an adequate oral health care program; however, it was determined, that the Facility was not in substantial compliance because a significant number of annual dental evaluations were not completed as required; there was no organized process to assess individuals for the need for suction toothbrushing, and no formal mechanism to assess the efficacy of oral toothbrushing; and there was no policy or procedure for dental emergencies. The Facility must develop a process to ensure that individuals who miss their scheduled dental radiographs are provided radiography, unless contraindicated.	
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;	To assess if the Facility maintained a process to ensure timely dental treatments, reduce the need for sedation, and assess the efficacy of oral health care, the Monitoring Team reviewed the dental scheduling process; the tracking and trending of missed dental appointments; oral intravenous (TIVA) and general anesthesia programs for dental sedation; programs to help reduce the need for sedation; and the Facility's quality assurance process for dental services. Dental Schedule and Completeness of Oral Health Care To assess if all individuals were current with their annual dental examination and all necessary treatments, the Monitoring Team requested a copy of the dental schedule for the past 12 months; a list of all individuals who were not current with their annual dental evaluation and scheduled dental treatments, along with the reason why they were not current; and necessary steps to get each individual current with their dental treatments.	Noncompliance

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	use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	The Monitoring Team was not provided with the specific information requested, but was provided with a list of one individual who was reported not current with the annual dental evaluation, the dental schedule and a summary of annual dental evaluations that occurred during October 2012 through March 2013. The Summary of annual dental evaluations documented the number of individuals seen and who were not seen as scheduled for their annual dental evaluation, but did not indicate if the actual examination was completed for those who were seen for their examinations. The Facility must have a process to track and trend individuals who were not provided all necessary evaluations and treatments, and the current process did not enable that type of review. The Monitoring Team was provided a copy of the Facility's dental schedule, and it was noted to be a spreadsheet that documented the time and date of the scheduled dental appointments, the name of the dentist, reason for referral, if the appointment was kept or not, and follow-up recommendations. The Monitoring Team noted that the spreadsheet provided relevant data elements; however, there was no process to enable a specific systems review, that included tracking and trending of missed appointments, and a quality improvement process to address system issues related to missed appointments. The Monitoring Team is assessing the efficacy of how the Facility utilizes tracking and trending of data elements. During discussion with the dental staff, the Monitoring Team was informed that approximately 30% of the population were not current with their annual dental evaluation and treatments, because of maladaptive behaviors. Also, as noted above, the Monitoring Team assessed that only 55% of the sample requested demonstrated completion of an annual dental evaluation. Summary: The Facility must develop a process to track and trend individuals who are not current with dental evaluations and treatments, and ensure that there are action steps developed to provide all necessary oral health care treatments at the level of the Individual, and for relevant system issues that maybe identified. <u>TIVA and Pre-Treatment Oral Sedation</u> The Facility reported that it did not have a process to provide individuals with total intravenous anesthesia for dental services, and did not currently provide individuals an opportunity for pre-treatment oral sedation. All individual who required any form of sedation because of challenging behaviors were referred for general anesthesia at the	

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		local hospital. General Anesthesia Mario Menchasca and Lorraine Hinrichs reported that at the time of this review, individuals who experienced challenging behaviors were referred for general anesthesia to complete their dental examination and treatments. The Facility provided a list of 13 individuals who were currently awaiting general anesthesia for their dental evaluation and treatments. Mario Menchasca and Lorraine Hinrichs also reported that the Facility did not have a process in place to adequately track and trend individuals who required the on-going need for sedation for dental evaluations and treatments. Summary: The Facility should explore, in collaboration with their community dentists, ways to provide dental evaluations and treatments, while employing less invasive therapies than general anesthesia, such as TIVA, or pre-treatment oral sedation, when clinically indicated. Programs to Help Reduce the Need for Sedation To assess the Facility's ability to reduce the need for sedation for dental evaluations and treatments, the Monitoring Team request all related policies and procedures, and was provided with Standard Operating Procedure ICF-IID 400 16: Pre-Medication for Medical and Dental Procedures, Revised August 2012. Also requested was a list of all individuals who had been assessed and those not assessed for a program to reduce the use of sedation; and for the first ten individuals on the alpha list of individuals provided a program, a copy of the program, and a trends analysis to assess efficacy of the program. Mario Menchasca and Lorraine Hinrichs informed the Monitoring Team that the Facility had developed and implemented a dental rehearsal program that helps to desensitize individuals to the dental office and dental procedures. Review of the policy provided did not delineate the current process the Facility reported as having. The Facility reported having developed and implemented a dental rehearsal plan for a total of 19 of the 63 (30%) individuals who resided at the Facility. During April, 2013, 13 out of 19 (68%) of individuals assigned a dental rehearsal, were provided a dental rehearsal on one occasion; four out of 19 (21%) were provided two dental rehearsals; and two out of 19 (10%) were provided three dental rehearsals. Summary: Although the Facility provides a dental rehearsal program to help reduce the need for	

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		sedation during dental procedures, the Monitoring Team determined that because of the infrequent opportunities offered for dental rehearsals, the program was unlikely to be effective. The Facility must enhance opportunities to help individuals better accommodate to dental services. <u>Dental Quality Assurance Program</u> Mario Menchasca and Lorraine Hinrichs informed the Monitoring Team that the Facility had yet to develop a dental quality assurance process. Summary: The Facility must develop a comprehensive quality assurance program for dental services that enables an assessment of dental treatments and potential adverse outcomes from dental treatments. <u>Conclusion</u> The Monitoring Team determined that the Facility was not in compliance with Provision Q.2 of the Settlement Agreement. The Facility must develop and implement a quality assurance process to assess the efficacy, and potential adverse outcomes, for dental services; develop and implement a clinically sound approach to providing sedation for dental treatments; enhance the frequency of its dental rehearsal program; and improve on tracking and trending system issues related to missed dental appointments.	

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

1. Ensure that individuals are evaluated and treated for dental issues as clinically necessary, per State policy, and per standard of care practice. (Provision Q.1 and Q.2)
2. Ensure that individuals who miss their scheduled dental radiographs are provided dental radiography. (Provision Q.1)
3. Develop a policy and procedure that reflect the Facility's current practice for oral health care. (Provision Q.1)
4. Develop a process to provide assessment for the need for suction toothbrushing. (Provision Q.1)
5. Develop a process to periodically assess efficacy of suction toothbrushing. (Provision Q.1)
6. Ensure that all dental evaluations and treatments are documented as an IPN, in language that non-dental professionals can understand. (Provision Q.2)
7. Ensure that dental hygiene is provided at the level of standard of care practice. In general, individuals should have dental hygiene provided at least every six months, and in some cases more frequently, unless contraindicated. (Provision Q.1)
8. Immediately review the practice for sedation, and ensure that individuals are provided the appropriate level of support for dental services. Some individuals may benefit form oral pre-treatment sedation, others may benefit from TIVA, while some may require full airway support and require general anesthesia. (Provision Q.1)
9. Enhance the dental rehearsal program to ensure that individuals who require dental rehearsal are provided more frequent sessions. (Provision Q.2)
10. Develop an oral health quality assurance process that assesses the quality, efficacy, and potential adverse outcomes to oral healthcare treatment.

(Provision Q.2)

11. Track and trend missed dental appointments, and develop system level corrective actions to improve on reducing the number of missed appointments, when necessary. (Provision Q.2)

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Self-Assessment, dated 4/29/13 2. RGSC Action Plan 4/25/13 3. RGSC Policy- 500-03 Communication Services (rev January 2010) 4. Facility Section R Presentation Book 5. Settlement Agreement Monitoring Tool for Section R Record Reviews of Individuals: 6. Sample R.1: Individuals #19, #31, #47, #55, #60, #77, #91, #97, #118, and #149 7. Sample R.2: No individuals received direct services 8. Sample R.3: Individuals #12, #82, #101, and #140 9. Sample R.4: Individuals #19, #77, #118, and #149 10. Sample R.5: Individuals #4, #19, #60, and #77 11. List of current SLPs, caseloads and ratios 12. Copies of each SLP's current license and ASHA certification 13. Continuing education and training completed by the SLPs in the past 12 months 14. Facility list of new admissions since the last review 15. Tracking log of SLP assessments completed since the last review 16. Facility list of individuals with severe language deficits 17. Facility list of individuals with PBSPs and replacement behaviors related to communication 18. PBSP minutes and attendance rosters for the past six months 19. Facility list of individuals with Alternative and Augmentative communication (AAC) devices 20. Facility AAC screening forms 21. Facility AAC-related database reports/spreadsheets 22. Facility list of general common area AAC devices 23. Facility list of individuals receiving direct communication-related intervention plans 24. Competency Based Training Forms for staff **People Interviewed:** 1. Belinda Lopez MA/CCC-SLP 2. Sotera Villalpando MA/CCC-SLP 3. Four Direct Support Staff (La Paloma and El Paisano) **Meetings Attended/Observations:** 1. Vocational Education 2. Mealtimes and Transitions (La Paloma, El Paisano)
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 4/29/13 and Action Plan dated 4/25/13. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating.

	Based on a review of the Facility's Self-Assessment, with regard to Section R of the Settlement Agreement, the Facility found it was in noncompliance with all Provisions. This was consistent with the Monitoring Team's findings of noncompliance with Provisions R.1, R.2, R.3 and R.4. For Section R in conducting its self-assessment, the Facility: • Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section R. o This monitoring/audit tool did include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools did include adequate methodologies, such as observations, record review and staff interview. o The Self-Assessment did not state the staff/positions who were responsible for completing the audit tools, such Facility therapists (i.e., SLPs); therefore there was no evidence that staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools. • The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. Overall, the Action Plans included relevant steps that would assist in the Facility in gaining compliance; however, the activities at times were not consistently in line with what the Monitoring Team assesses as indicated in this report. RGSC should continue to review the Monitoring Team's reports to ensure indicators and areas of self assessment are aligned with the provisions in the report. An example of this would be to move areas focused on the assessment content from Provision R.1 to R.2.
	Summary of Monitor's Assessment: 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. A number of concerns remained. While there was some improvement noted for collaboration of Speech Services and Psychology, there still needed to be more collaboration with behavior supports so that there was a cohesive approach to addressing behaviors that had communication as a primary component. Other concerns focused primarily on the Facility's inability to complete assessments in a timely manner and provide detailed monitoring that clearly demonstrated progress and the functional intent of the programs.

	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, staff reported that due to responsibilities and expectations, they did not have time to address all of the individuals needs in a timely manner. **Provision R.2:** This provision was determined to be not in compliance. Assessments were not completed in a timely manner and the communication assessments did not consistently include the manner in which strategies, interventions, and programs should be utilized throughout the day **Provision R.3:** This provision was determined to be not in compliance. AAC devices were not consistently utilized by individuals. Additionally, DSPs interviewed were not consistently knowledgeable of the communication programs. **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.

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	Samples for this section are as follows: Sample R.1: Consisted of 10 Individuals identified by the Facility with severe expressive or receptive language disorders with assessments completed in the last 12 months. Sample R.2: Would normally consist of Individuals receiving direct speech services, but RGSC was not providing direct Speech services and therefore this sample could not be gathered. Sample R.3: Consisted of four Individuals with a PBSP and communication deficits. Sample R.4: Consisted of four Individuals from Sample R.1 above with AAC systems. Sample R.5: Consisted of four individuals who had indirect communication plans (SAPs) developed. <u>Staffing</u> The Facility was in the process of determining what an appropriate caseload would be for SLPs at RGSC. The process to be used by RGSC in determining the need for SLPs will include an analysis of SLPs' responsibilities, including consideration of the acuity of individuals' speech and communication needs. Such responsibilities included but were	Noncompliance

#	Provision	Assessment of Status	Compliance
		not limited to conducting assessments, developing and implementing programs, providing staff training, and monitoring the implementation of programs. As of this review, RGSC had two full time SLPs. The current staffing allowed for a caseload of approximately 32 individuals, which appeared to be reasonable to conduct the daily activities and responsibilities of the SLP. However, per interview with the SLPs, it was stated that they had so many responsibilities that they had difficulty meeting all the deadlines as well as the needs of the individuals. Also stated was that many of these responsibilities were in areas in which clerical and support staff could be utilized. Therefore, the Facility did not provide an adequate number of speech language pathologists or other professionals (i.e. AT specialists) with specialized training or experience. <u>Qualifications</u> Two of two positions for SLPs (100%) were filled by licensed SLPs • Two of two SLPs (100%) were licensed to practice in the state of Texas. • Two of two SLPs (100%) had evidence of ASHA certification. <u>Continuing Education:</u> Based on a review of continuing education completed in the last 12 months, five of five SLP staff (100%) had completed continuing education related to communication in an area that was relevant to the population served. Education included but was not limited to: • Issues in Evaluation and Treatment of Individuals with Developmental Disorders • The MBSImp and Dysphagia Practice: Targeted Intervention through Standardized Physiologic Swallow Assessment <u>Facility Policy</u> A local policy/process did not provide clear operationalized guidelines regarding the delivery of communication supports and services and outlines minimum components of communication supports and services. RGSC provided a policy titled "Communication Services" that was last revised in January 2010. The following components were included in this policy: • Roles and responsibilities of the SLPs (meeting attendance, staff training etc.) • Outline of assessment schedules • Frequency of assessments/updates • Timelines for completion of new admission assessments • Timelines for completion of comprehensive assessments	

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		• Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication • Process for effectiveness monitoring by the SLP • Criteria for providing an update Missing from the policy were the following components: • Process for effectiveness monitoring by the SLP • Methods of tracking progress and documentation standards related to intervention plans • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution • Monitoring for the presence of communication adaptive equipment or other AAC supports/materials • Monitoring for the working condition of communication adaptive equipment • Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work) • The frequency of monitoring for individuals within the established Master Communication Plan priority levels • The process for identification, training, and validation for monitors • The process of inter-rater reliability	
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> The Facility had a reasonable plan to screen all individuals and, based on priority need, assess individuals who would benefit from the use of alternative or augmentative communication systems. RGSC provided assessments for all new admissions. Individuals at a minimum are provided with a Comprehensive Communication Assessment every three years along with an annual update should the individual be provided with direct or indirect services related to communication. Part of the annual update was a review of all areas within the assessment including but not limited to expressive and receptive language, medications, and vision and hearing. Additionally a screening was conducted as part of the communication update to further determine if there had been a change in status that would warrant another comprehensive assessment. **<u>Assessments Provided</u>** Ten of 10 individuals in Sample R.1 (100%) were provided a communication assessment per policy and/or Master Plan. All individuals in Sample R.1 received assessments annually if the individual was provided with direct or indirect services and at least every	Noncompliance

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		three years for all individuals. Two of two admitted individuals (100%) since the last review received a communication screening or assessment within 30 days of admission or readmission. For five of 14 individuals in Samples R.1 and R.3 (35%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP. Failure to provide the assessments in a timely manner resulted in a lack of the IDT to be able to discuss the findings and recommendations as well as integrate the result into the ISP document. Fourteen of fourteen individuals in Samples R.1 and R.3 (100%) who were provided direct or indirect communication supports and services had an assessment or update current within the last 12 months. <u>Communication Assessment</u> Based on review of the sample of assessments (Samples R.1 and R.3), the comprehensiveness of the communication assessments were as follows: 1. The Monitoring Team was unable to determine if SL assessments (100%) were signed and dated by the clinician upon completion of the written report as the Facility did not provide copies of the original documents; 2. Five of 14 individuals' SL assessments (35%) were dated as completed at least 10 working days prior to the annual ISP; 3. Fourteen of 14 individuals' SL assessments (100%) included diagnoses and relevance of impact on communication; 4. Fourteen of 14 individuals' SL assessments (100%) included individual preferences, strengths, and needs; 5. Fourteen of 14 individuals' SL assessments (100%) included medical history and relevance to communication; 6. Fourteen of 14 individuals' SL assessments (100%) listed medications and discussed side effects relevant to communication; 7. Zero of 14 individuals' SL assessments (0%) provided documentation of how the individual's communication abilities impacted his/her risk levels; 8. Zero of 14 individuals' SL assessments (0%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day. An example was Individual #77's assessment, which just stated that communication strategies should be integrated into the daily schedule but provided no further detail or instruction. 9. Fourteen of 14 individuals' SL assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work);	

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		10. Nine of 14 individuals' SL assessments (64%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not fully and effectively communicate verbally; 11. Four of 14 individuals' SL assessments (28%) included discussion of the expansion of the individuals' current abilities. The SLP assessment did not discuss how an individual's current abilities could be enhanced by direct and/or indirect interventions, including skill acquisition programs; 12. Fourteen of 14 individuals' SL assessments (100%) provided a discussion of the individuals' potential to develop new communication skills; 13. Ten of the 14 individuals' SL assessments (71%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification and rationale as to whether or not the individual would benefit from AAC or EC. The majority of assessments limited exposure to AAC to the assessment itself, and if the individual did not initially respond in a positive manner to the devices then the device was no longer in consideration. 14. Fourteen of 14 individuals' SL assessments (100%) offered a comparative analysis of health and functional status from the previous year 15. Fourteen of 14 individuals' SL assessments (100%) gave a comparative analysis of current communication function with previous assessments 16. Eleven of 14 individuals' SL assessments (78%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. 17. Fourteen of 14 individuals' SL assessment (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; 18. Fourteen of 14 individuals' SL assessments (100%) had a reassessment schedule; 19. Zero of 14 individuals' SL assessments (0%) supplied a monitoring schedule. The SLP assessment did not discuss monitoring results from the previous year and did not recommend the implementation of a monitoring schedule for the upcoming year. 20. Fourteen of 14 individuals' SL assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits. 21. Fourteen of 14 individuals' SL assessments (100%) made a recommendation about the appropriateness for community transition. 22. Zero of the 14 individuals' SL assessments (0%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. While strategies were provided as part of the Communication Assessment, there was limited evidence regarding how strategies could be implemented throughout the day and integrated into various SAPs. <u>SLP and Psychology Collaboration:</u> Based on review of four individuals' records (Sample R.3) with Positive Behavior Support	

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		Plans (PBSPs) the following was noted: 1. Four of four communication assessments reviewed (100%) contained evidence of review of the PBSP by the SLP. This was noted in the behavioral considerations section of the SLP assessment. 2. For zero of four individuals (0%) communication strategies identified in the assessment were included in the PBSP. 1. For zero of four individuals (0%) communication strategies identified in the assessment were included in the ISP. Based on review of the Positive Behavior Support Committee meeting attendance sheets from 9/24/13 to 2/25/13, participation by a SLP was noted in zero of the 18 meetings (0%). The SLP at the time of the review was not participating as a member of the Behavior Services Peer Review 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. This did not appear to be consistently occurring as evidenced by the lack of integration and collaboration of the plans of care.	
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> Based on review of the ISPs for individuals in Sample R.1 and R.3 the following was noted: • In seven of 14 ISPs reviewed (50%) for individuals with communication needs an SLP attended the annual ISP planning meeting, or the team provided adequate justification as to why the SLP was not needed. • Six of 14 ISPs reviewed (42%) included a description of how the individual communicated and how staff should communicate with the individual, including the AAC system if he/she had one. Examples included but were not limited to: a. Individual # 31's ISP only stated that staff would need to know how to communicate with the Individual. b. Many ISPs were out of date and therefore integration was not noted. • Communication Dictionaries for 8 of 14 individuals (57%) were reviewed at least annually by the IDT as evidenced in the ISP and ISPAs. An example of good practice was noted during the IDP planning meeting for Individual #118. During the meeting, the IDT (including the DCP) revised the individual's communication dictionary. This observation offered an excellent example of integrated planning and discussion.	Noncompliance

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		• Zero of 14 ISPs reviewed (0%) included how communication interventions were to be integrated into the individual's daily routine. • Six of 14 ISPs reviewed (42%) contained skill acquisition programs to promote functional communication. Strategies were not integrated into existing SAPs and SAPS were not developed to address identified concerns with communication. • Zero of 14 ISPs reviewed (0%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. <u>Development And Implementation Of Functional Individual-Specific Assistive Communication Systems</u> No revisions were recommended for the communication dictionaries; therefore whether modifications were made in a timely manner was unable to be determined and will be reviewed at the next visit. Observations were conducted in homes with AAC systems in Sample R.4. Findings included the following: • Two of four observations (50%) found AAC devices present in each observed setting and readily available to the individual. • AAC systems for zero of four individuals (0%) were noted to be in use in each observed setting. • AAC systems for four of four individuals (100%) were portable. • AAC systems for four of four individuals (100%) were functional. • For four of four individuals (100%), staff instructions/skill acquisition plans related to the AAC system were available. A concern noted by the Monitoring Team was that there were many SAPs identified as part of the Communication Assessment that were not implemented. Examples included Individuals #12, #31 and #140. Additionally, RGSC reported as part of their entrance that only 14 of 22 SAPS had been implemented since the previous visit. <u>General Use AAC Devices</u> RGSC had 64 common/general area shared devices available for use throughout the Facility. These locales included Vocational Education, Dining Rooms, and Home Common Areas. Observations were completed in two homes and Vocational Education to determine the presence and use of general AAC devices. Findings included the following: • Three of the three areas and other environments observed (100%) had general use AAC devices present in the common areas.	

#	Provision	Assessment of Status	Compliance
		• In zero of three areas and other environments (0%), all general use AAC devices were operational. • Twenty-one of the 64 general use AAC devices (32%) noted contained clear directives on how staff should use these devices. Directions were vague and did not provide detailed instructions/directions to ensure consistent staff implementation. • Sixty-four of 64 general use AAC devices (100%) noted had a clear function within that setting/situation. • Zero of 64 general use AAC devices noted (0%) were used. Observations were provided in which the use of the board/devices would have been appropriate (for example: mealtimes, washing hands, oral care) but were not prompted by staff or utilized by the individuals. <u>Direct Communication Interventions</u> RGSC was not providing direct therapy and therefore the Monitoring Team could not review this area. That being said, there were a number of individuals who would likely benefit from such a service especially as it relates to those in which individuals were identified as being not stimulable to AAC or other methods of environmental interaction during the evaluation but would likely be more responsive through more intensive treatment or exposure.. An example was Individual #101 who did not initially respond to therapy, but given increased exposure would potentially improve receptiveness to alternative methods of communication. <u>Indirect Communication Supports</u> Programs for individuals in Sample R.1 who received indirect communication supports were reviewed. Overall there was a lack of indirect communication programs; therefore PNMPs that included communication strategies were included as indirect supports. • Ten of 10 individual's indirect plans (i.e., PNMPs, Dictionaries) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. • For seven of 10 individuals' records (70%) reviewed, the current SLP assessment identified the need for indirect intervention with rationale. For zero out of four individuals in Sample R.4 (0%), staff instructions were provided for individuals' AAC devices, including written step-by-step instructions; missing from the instructions were pictures identifying the device to be used. Zero of four individuals (0%) receiving indirect Speech Services (Sample R.5) were provided with comprehensive progress notes that contained each of the indicators listed below.	

#	Provision	Assessment of Status	Compliance
		• Quarterly documentation for one of 4 individuals (25%) contained information regarding whether the individual showed progress with the stated goal(s) or objectives. Review consisted of only stating that the service was provided and offered no information regarding effectiveness of supports in meeting desired outcomes. • Quarterly documentation for zero of 4 individuals (0%) identified the benefit of device and/or goal(s). • Quarterly documentation for zero of 4 individuals (0%) identified consistency of implementation. • Quarterly documentation for zero of 4 individuals (0%) identified recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress. <u>Staff Interviews</u> Two of four staff interviewed (50%) were knowledgeable of the individual and their communication related programs; direct support professionals had difficulty with the following questions • Whether there was a communication program. • Describing the communication program goal. • Described the schedule for implementation of the communication program. • Identifying how communication skills in the program were addressed throughout the day. <u>Competency-Based Training and Performance Check-offs</u> Based on review of the NEO training curriculum, , RGSC did develop comprehensive competency based training regarding communication services. • The training materials reviewed did address all the appropriate content areas listed below: a. Methods to enhance communication b. Implementation of programs c. Benefits and use of AAC d. Identification of non-verbal means of communication. 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 Sixteen of sixteen new employees (100%) had completed NEO core communication competencies for foundational skills and performance check-offs since the last review.	

#	Provision	Assessment of Status	Compliance
		Individual-Specific Competency-Based Training To determine whether the Facility had a process to determine whether staff had been trained on components of PNMPs for individuals they supported, the Monitoring Team requested evidence that all assigned staff for the 14 individuals in Sample R.1 had received training related to Communication SAPs and programs. Ten of 14 (71%) staff assigned had completed competency check-offs regarding the individuals' communication programs. Staff responsible for training other staff did successfully complete competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' plans prior to training others. The Facility did have a process to validate that staff responsible for training other staff are competent to assess other staff's competency.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	Policy and Procedure A Facility policy and/or procedures did not exist that describes the monitoring system for the communication provision of the ISP for individuals who would benefit from AAC. The Facility policy and/or procedures did not include the essential components related to monitoring. See Provision R.1 for additional information. Monitoring of Implementation of Communication Supports The Monitoring Team reviewed Compliance Monitoring forms for implementation of communication supports the last six months for three individuals from Sample R.5 and the following was found: • For zero of four individuals (0%), monitoring of communication supports was outlined in the assessment. • For zero of four individuals (0%) monitoring of their communication supports occurred at the frequency established by Facility policy or ISP. AAC monitoring was conducted that focused on presence and working condition, but this monitoring lacked consistent review of whether the plans/devices remained appropriate or the frequency in which the devices were being utilized. Per observations, underutilization of the devices was an area of concern noted by the Monitoring Team.. Zero of four individuals from Sample R.5 (0%) received monthly and/or quarterly	Noncompliance

#	Provision	Assessment of Status	Compliance
		monitoring to ensure all communication supports remained effective and functional. See Provision R.3 for additional information.	

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

1. RGSC should review the roles and responsibilities of the Speech Therapists in an effort to identify why the needs of the individuals are not being met in a timely manner. Part of this review should be prioritizing duties of the therapists in an effort to streamline responsibilities. (Provision R.1)
2. The Communication Services policy should be revised to further define the monitoring process and expectations of staff. (Provision R.1)
3. Individuals who were identified as having severe language/speech difficulties should be provided with a communication program that is based on the individual's strengths and provides a clear path to improved communication. (Provision R.2)
4. Integration must improve 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)
5. Indirect Communication Programs should be reviewed at a minimum monthly by the QDDP and quarterly by the SLP in an effort to determine if progress is being made and if any modifications are needed. (Provision R.3)
6. Communication Assessments must be completed in a timely manner (10 working days prior to the ISP) to allow for proper integration into the ISP and discussion amongst team members. (Provision R.2)
7. General/Common Area AAC devices should have directions consistently provided next to the device so that staff understands the context in which they can be used. (Provision R.3)
8. Communication strategies and devices used in SAPs should be integrated into all areas so that the likelihood of generalization may occur at a potentially faster rate. (Provision R.3)

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Self-Assessment 4/29/13 2. RGSC Action Plan 4/25/13 3. RGSC May 2013 Presentation notes 4. Documents that were reviewed included the annual ISP, ISP updates, Skill Acquisition Plans (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 Facility Self-Assessment and Facility Action Plans. 5. A sample of four individuals was selected for the review of RGSC's most recent SAPs and ISPs. The specific individuals included in the sample were Individuals #61, #63, #97, and #149. 6. A sample of 10 individuals was selected for the review of RGSC's OT/PT SAPs and ISPs. The specific individuals included in the sample were Individuals #8, #35, #40, #77, #79, #84, #85, #97, #108, and #139. 7. A sample of five individuals was selected for the review of RGSC's SLP SAPs and ISPs. The specific individuals included in the sample were Individuals #4, #19, #60, #77, and #84. 8. A sample of five individuals was selected for the review of RGSC's Dental SAPs and ISPs. The specific individuals included in the sample were Individuals #8, #55, #98, #101, and #139. **People Interviewed:** 1. George Romero – QDDP Coordinator 2. All QDDPs 3. Vanessa Alvarez – Human Rights Committee Chair 4. Ruben Nieto, BCBA – Psychology Director 5. Samantha Salinas, MSW – Contract Associate Psychologist 6. Cheryl Fielding, PhD, BCBA – Contract Psychologist 7. Alonzo Andrews, M.A., BCBA – Contract Psychologist 8. Direct Support Professionals: Approximately 15 staff members in residences, classrooms and vocational settings **Meeting Attended/Observations:** 1. Peer Review Committee (PBSC) 2. Human Rights Committee (HRC) 3. Observations were conducted in all residences, classrooms, vocational settings, and leisure areas on 5/14, 5/15, and 5/16.
	Facility Self-Assessment: At the time of the site visit, RGSC reported that Provision S.3.b was in substantial compliance with the SA.

	The Monitoring Team was not in agreement with the Facility. Provision S.3 requires that the 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. Provision S.3.b goes on to stipulate that these programs be implemented to the degree practicable in the community. Based upon the information obtained during the site visit, the Facility had not been able to ensure that necessary skill assessments had been completed, were accurate, and had been used in the development of skill acquisition programs. Furthermore, although the Facility had identified 45 community SAPs for 39 individuals, there was little to support that these programs were consistently and formally implemented in community settings. In general, the Self-Assessment completed by the Facility was lacking key components. The Facility did indicate sample sizes for some provision items, but not consistently. In addition, the Facility did not indicate the process or tool that was used to assess any provision, stating only that elements had been reviewed and the percentage of those elements that were in compliance. The value of the Self-Assessment was also limited by the stated focus upon quantitative rather than qualitative measures. For example, the Self-Assessment often included statements such as, "the SAPs are in the standard SAP format and the required components are in the plans", without assessing or addressing whether the quality of those components were sufficient. Without assessing the quality of the elements required by a provision, the Facility was unable to ensure whether those elements met the criteria of the Settlement Agreement. The Facility also presented an Action Plan to outline the steps that would be taken to establish compliance with the Settlement Agreement. Much like the Self-Assessment, the Action Plan emphasized quantitative rather than qualitative criteria for compliance. It was also unclear how or when the Action Plan would be carried out. Every element in the Action Plan had a start date of 5/1/2013 and a projected completion date of 5/31/2013; it was also stated for each element that implementation had not begun. Based upon information in the Self-Assessment and Action Plan, as well as observations conducted during the site visit, it was not suggested that RGSC had developed and implemented a coherent process for either achieving compliance with the Settlement Agreement or monitoring progress toward that goal.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RGSC from 5/13/2013 through 5/17/2013. 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 did demonstrate progress in some discrete areas. These areas of progress included the following. • Communication SAPs reflected relatively greater compliance with expectations than other SAPs. • The Facility had maintained acceptable levels of engagement and active treatment in some

	settings. Despite these areas of relative strength, the Facility demonstrated substantial difficulty in achieving more global progress toward compliance with the Settlement Agreement. Areas of particular concern are presented below. • A substantial portion of skill assessments were either submitted late or not at all, substantially limiting the ISP process. • Skill acquisition programs continued to reflect a lack of attention to accepted teaching practices and were unlikely to strengthen skills. • The performance of the IDT did not reflect familiarity with or application of evidence-based practices. In some circumstances, the IDT had approved SAPs that were based upon procedures that research had not demonstrated were effective or appropriate. Based upon observations, record reviews, and other information obtained during the site visit process, it was not apparent that the Facility had the necessary systems or procedures in place to satisfy the requirements of the Settlement Agreement. Especially troubling were indications that the Facility did not recognize when problems existed in assessments, SAPs, or teaching efforts. Without substantially enhanced efforts, the Facility is likely to find compliance with the Settlement Agreement substantially more difficult to attain.

#	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, and freedom from undue use of restraint.	<u>Historical Perspective</u> 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. During the August 2012 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 resulted in a review of two ISPs and seven SAPs. Based upon the information obtained and records reviewed, there was little indication that the Facility had substantially improved upon previous efforts. There was little indication that the Facility had provided adequate assessment in relation to skill acquisition training or that the new ISP process offered meaningful improvement in the use of assessments in the development of skill acquisition programs. Some modest improvement was noted in some elements of the reviewed SAPs.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Current Site Visit During the current site visit, a sample of 24 SAPs was selected. This sample included four SAPs developed during the four most recent ISPs (one per ISP), five dental rehearsal SAPs, five SLP SAPs, and 10 OT/PT SAPs; The dental, OT/PT, and SLP SAPs were selected by the Facility. One individual, Individual #97, was included in both the OT/PT and most recent ISP samples. In each of the two samples, a different SAP was selected for Individual #97. Use of Assessment Information in Planning Skill Acquisition 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. Given the lack of assessments, it was often difficult to determine whether there was adequate rationale for selection of skills for acquisition training. Based upon all SAPs reviewed, there was little indication that the Facility had provided adequate assessment in relation to skill acquisition training.	

	02/2010	08/2012	5/2013
Skill acquisition plans are implemented to address needs identified in:	0%	0%	0%
ISP	0%	0%	8%
Adaptive skill or habilitative assessment	0%	0%	8%
Psychological assessment	0%	0%	0%
Skill acquisition plans are chosen in an individualized manner.	0%	0%	8%
Skill acquisition plans are related to the individual's preferences.	0%	0%	8%

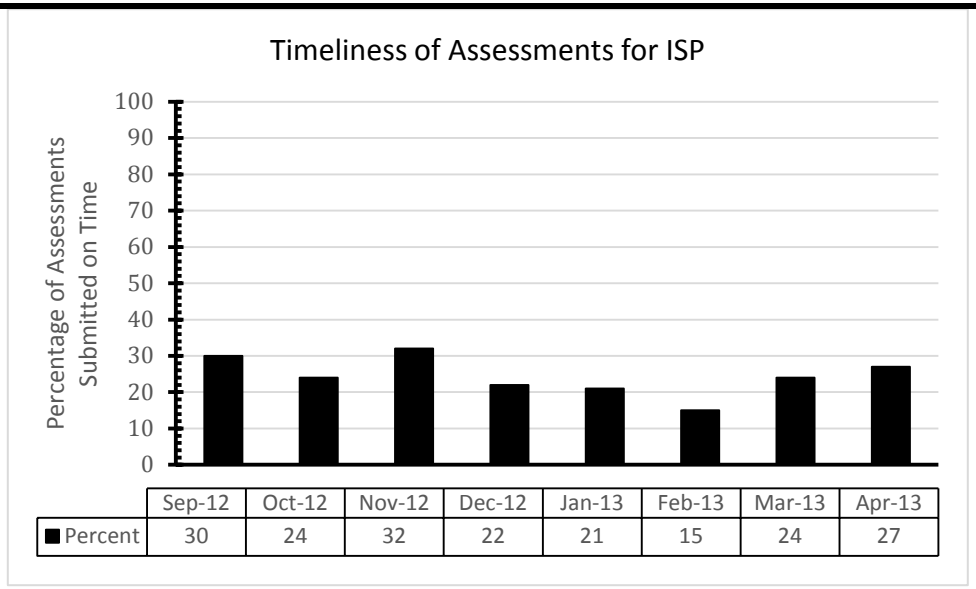
When broken down by sample, there were indications that some disciplines were achieving at least limited success at basing SAPs upon assessments. Although not approaching the level required for substantial compliance, the SLP SAPs at times were based upon adequate assessment. Even when the SAPs reflected assessment results, the integration of assessment results with the development of SAPs was frequently lacking in ISP documentation. Additionally, it was not documented that adaptive skill needs identified in Psychological Assessments were considered by the interdisciplinary team as part of the ISP process.

#	Provision	Assessment of Status	Compliance

	Total	OT/PT	Dental	SLP	Recent
Sample Size	24	10	5	5	4
Skill acquisition plans are implemented to address needs identified in:	0%	0%	0%	0%	0%
ISP	8%	0%	0%	20%	25%
Adaptive skill or habilitative assessment	8%	0%	0%	40%	0%
Psychological assessment	0%	0%	0%	0%	0%
Skill acquisition plans are chosen in an individualized manner.	8%	0%	0%	40%	0%
Skill acquisition plans are related to the individual's preferences.	8%	0%	0%	40%	0%

The lack of adequate assessment for SAPs was in part due to the use of sensory-integration in all of the reviewed OT/PT SAPs. Despite the use of acceptable OT/PT assessments that reflected meaningful data, the recommendations offered by the OT/PT staff did not incorporate these assessment data. Rather, the SAP recommendations offered in the assessment reports reflected procedures such as brushing and compression clothing. There were no data presented to support that any individual desired, experienced reinforcement due to, or benefitted in any way from these procedures. Rather, the assumption was expressed that brushing and compression clothing would "help the mind-brain-body organize". The Facility did not reference or discuss any research to indicate that this was an evidence-based treatment approach or that any individuals met diagnostic or other criteria for which this approach has been validated.

One additional factor that could have contributed to the poor integration of assessments in ISP discussions was the lack of available assessment reports. Based upon tracking data maintained by the Facility, it was uncommon to have more than 25% of the required assessment reports completed and submitted in time for the ISP meetings. It was not possible to determine from available data whether the lack of an assessment report contributed to the failure to integrate assessment findings with any specific SAP. Of particular concern, however, was the failure of the IDT to acknowledge in the ISP the lack of assessments and attempt to compensate for the lack of assessment reports with valid data from other sources.

#	Provision	Assessment of Status	Compliance
		 Based upon information provided by RGSC, there were only modest achievements by some disciplines in the use of assessments as part of the development of skill acquisition programs. Concerns about the lack of comprehensive improvement was compounded by the chronic lack of necessary assessment reports at the time of the ISP annual planning meeting, as well as the acceptance of SAP recommendations that involved scientifically disputed procedures with no evidence to support individual benefit. As a result, it was suggested that the Facility was unable to ensure that adequate assessments were provided and used to support the development of individualized skill acquisition programs. <u>Teaching New Skills</u> 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. The 24 SAPs provided by RGSC routinely lacked several of the essential components of a	

#	Provision	Assessment of Status	Compliance
		skill acquisition program. Furthermore, the SAPs reflected no comprehensive improvement in comparison with previous SAPs, and often lacked components that had been documented in SAPs during previous site visits. Modest improvements were noted in five areas, the greatest being an increase of 21% in relation to the use of reinforcement. However, regression was noted in four areas.	

	02/2010	08/2012	05/2013
Plan reflects development based upon an individualized task analysis	0%	0%	0%
Behavioral objective(s)	0%	14%	17%
Operational definitions of target behavior	0%	0%	17%
Description of teaching conditions	0%	0%	0%
Schedule of implementation plans for sufficient trials for learning to occur	0%	29%	0%
Relevant discriminative stimuli	0%	57%	38%
Specific instructions	0%	0%	8%
Opportunity for the target behavior to occur	0%	86%	33%
Specific consequences for correct response	0%	0%	21%
Specific consequences for incorrect response	0%	14%	13%
Plan for maintenance and generalization that includes assessment and measurement methodology	0%	0%	0%
Documentation methodology	0%	86%	4%

When broken down by sample, it was evident that some disciplines were demonstrating more progress than others were.

- For the Dental Rehearsal SAPs, the following improvements were noted.
  - Five of five SAPs (100%) included relevant discriminative stimuli and opportunities for the target behavior to occur.
  - Three of five SAPs (60%) included behavioral objectives and operational definitions.
  - Three of 12 areas (25%) reflected improvement of at least 40% over the previous site visit.
  - Four of 12 areas (33%) reflected some improvement.

- For the SLP SAPs, the following improvements were noted.
  - Three of five SAPs (60%) included specific consequences for correct responses.
  - Two of 12 areas reflected improvement of at least 40% over the previous site visit.

#	Provision	Assessment of Status	Compliance
		o Six of 12 areas (50%) reflected some improvement The area of greatest weakness involved the OT/PT SAPs. None of the 10 reviewed SAPs (0%) met criteria for compliance in any area. As a result, these SAPs suppressed the aggregate ratings for SAPs. Although this might be considered excessive influence on scores by one discipline, it must be remembered that the IDT had final authority on all SAPs. As all 10 SAPs were approved by the IDT, there was reason to believe that the IDT lacked the ability to identify and develop skill acquisition programs that promoted the growth, development, and independence of all individuals.	

	Total	OT/PT	Dental	SLP	Recent
Sample Size	24	10	5	5	4
Plan reflects development based upon an individualized task analysis	0%	0%	0%	0%	0%
Behavioral objective(s)	17%	0%	60%	20%	0%
Operational definitions of target behavior	17%	0%	60%	20%	0%
Description of teaching conditions	0%	0%	0%	0%	0%
Schedule of implementation plans for sufficient trials for learning to occur	0%	0%	0%	0%	0%
Relevant discriminative stimuli	38%	0%	100%	60%	25%
Specific instructions	8%	0%	0%	40%	0%
Opportunity for the target behavior to occur	33%	0%	100%	40%	25%
Specific consequences for correct response	21%	0%	0%	60%	50%
Specific consequences for incorrect response	13%	0%	0%	20%	50%
Plan for maintenance and generalization that includes assessment and measurement methodology	0%	0%	0%	0%	0%
Documentation methodology	4%	0%	0%	20%	0%

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.

It was not evident from a review of the documentation that staff at RGSC had a clear understanding of task analyses, chaining procedures, and skill acquisition training. Although there were numerous references to task analyses, there was no indication that

#	Provision	Assessment of Status	Compliance
		any actual task analyses had been conducted. Rather, the Facility appeared to be using the term task analysis to refer to the steps in a chaining procedure without recognizing that a task analysis is the process by which those steps are identified. As stated previously, a task analysis is only primarily required if a chaining procedure is to be used in teaching a skill. As the majority of SAPs at RGSC made use of chaining procedures, then the ability to perform a task analysis and develop a chaining methodology was essential. <u>Behavioral objectives:</u> It is essential that efforts to strengthen skills include objectives comprised of observable and measurable elements of the behavior. Only four of the 24 SAPs (17%) included an objective stated in measurable and observable terms. In the remaining 20 SAPs (83%), the goal for a training program consisted of a general statement that did not clearly indicate what specific skill or behavior was to be increased. As a result, it was not evident how the objective related to the specific needs of the individual or contributed to enhancing the individual's abilities. • For Individual #60, the objective statement was "When presented with pictures of colors, [the Individual] will imitate 8/8 colors within 6 months". The goal statement lacked an indication of the number of successful trials sufficient for completion of the program. As written, a single successful trial could be interpreted as completion criteria. Furthermore, it was unclear what an individual would do to "imitate a color." • For Individual #84, the objective was stated as follows: "When given a visual (communication notebook) prompt, [the Individual] will request clothes to wear while getting dressed (morning and evening) through imitation in 3/5 trials (shirt, pant, socks, shoe, belt)[Expected Completion Date]". It was not possible to determine from this statement the specific behavior that was expected. Furthermore, it was not stated with sufficient specificity if the number of successful trials required for success was per item, per day, per teaching session, or some other time requirement. <u>Operational definitions</u> 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. Only four of the 24 SAPs (17%) included adequate operational definitions of targets. In the remaining 20 SAPs (83%), the operational definition was stated in general terms or no operational definition was provided. • For ten of 10 OT/PT SAPs (100%), no operational definition of expected individual	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>behavior could be provided as the SAP consisted of behaviors that staff rather than the individual would perform.
o For Individual #84, the steps of the OT/PT SAP consisted of the following steps below. As the staff rather than the Individual was engaged in the behavior (that is, “brush back 10 strokes” is an action the staff, not the individual, was expected to do), there was no opportunity for the individual to experience reinforcement for the display of a specific skill that the program was implemented to teach or increase.

<table>
<tr><td>Step</td><td>Task</td></tr>
<tr><td>1.</td><td>Brush Back 10 Strokes top to bottom (over or under shirt)</td></tr>
<tr><td>2.</td><td>Brush arms 10 strokes top to bottom (over or under shirt)</td></tr>
<tr><td>3.</td><td>Brush tops and palms of hands 10x each</td></tr>
<tr><td>4.</td><td>Brush legs 10 strokes top to bottom (over or under clothes)</td></tr>
<tr><td>5.</td><td>Brush tops and bottoms of feet 10 strokes.</td></tr>
<tr><td>6.</td><td>Joint compression to shoulders 10 firm pushes into joint</td></tr>
<tr><td>7.</td><td>Joint compression to wrist and elbows 10 firm pushes into joint</td></tr>
<tr><td>8.</td><td>Joint compression to hip, knee and ankle 10 firm pushes into joint.</td></tr>
</table>

• For Individual #61, the operational definition stated that the individual would label objects within the environment. Although labeling is a term used by SLPs to designate identifying environmental objects, the term is not frequently used as such in the general population. As a result, this definition introduced the probability of confusing DSP staff and other non-SLPs who might be tasked with implementing the program. If the required behavior was intended to be stating the name of the object, the SAP should state that and not use jargon.

<u>Description of teaching conditions:</u> 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 may be ineffective and can strengthen the wrong behavior. Of the training programs reviewed at RGSC during the current site visit, none of 24 SAPs (0%) had adequate details to ensure that training could be implemented consistently.

<u>Sufficient trials:</u> 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</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		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. 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 nine of the 24 SAPs (38%), conditions were described in the SAP that could have served as a discriminative stimulus. For an event actually to 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. 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. Only two of the 24 SAPs (8%) included adequate instructions for staff. • For individual #149, the instructions included three statements: "[The individual] will obtain ear molds from nurse prior to bathing; Staff will instruct [the individual] to go to the nurse station to get her ear molds; and [the individual] will put on ear molds." No instructions were provided regarding how or when to prompt the individual, under what conditions reinforcement was to be offered, or what constituted success. • For Individual #63, several steps in the teaching process for brushing teeth allowed for considerable error. The first step of the SAP included all aspects of preparing the toothbrush while the final step included all aspects of cleaning up. The wording of these two steps suggested that the individual might not have the ability to complete these steps, and prompted the teacher to review separate SAPs addressing these skills. No such SAPs were provided for the individual. 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.	

#	Provision	Assessment of Status	Compliance
		• In 19 of 24 SAPs reviewed (79%), no specific reinforcing consequence was described. • In one of 24 SAPs reviewed (4%), a correct request was followed by the delivery of the requested item. The delivery of this item was likely to strengthen the correct requesting behavior. • In four of 24 SAPs reviewed (17%), 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 receiving training. There was no indication that the necessary reinforcer or preference assessments, or other evidence that praise has been effective as a reinforcer for this individual, had been completed for the individuals for whom the SAPs had been developed; therefore, there was no way to assess whether praise might serve as an effective reinforcer. 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 three of 24 SAPs (13%) 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 provided no response to be given following incorrect trials. <u>Plan for maintenance and generalization:</u> 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, 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. None of the 24 the skill acquisition programs reviewed at RGSC (0%) included specific plans for generalization. <u>Documentation Methodology:</u> In order to determine if a skill acquisition program was successful, there must be a valid and reliable method of measuring and documenting the performance of the person being taught. The data collection process must provide specific instructions for when to document performance, how to record the data, and the forms or tools that are to be used. In addition, an adequate data collection system must involve	

#	Provision	Assessment of Status	Compliance

collecting data with sufficient frequency to ensure that a valid estimate of individual performance is achieved. RGSC was unable to demonstrate that an adequate data collection system was used for the majority of SAPs.

- In one of 24 SAPs reviewed (4%), there was an adequate description of documentation practices.
- For all 10 of the OT/PT SAPs (42% of the sample), data collection of individual skill development was not possible, as the SAPs did not involve the teaching of new skills.
- For the remaining 13 of 24 SAPs (54%), instructions for data collection and documentation were vague, poorly developed and allowed for data to be collected too infrequently to be meaningful.

<u>Implementation of formal and informal skill acquisition training</u>

The Monitoring Team conducted observations in a variety of settings across the RGSC campus. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. 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.

	Staff Present	Individuals Present	Individuals Functionally Engaged	Percent Functionally Engaged
502 Main	1	2	0	0%
502 Classroom	4	6	1	17%
501 Main	1	3	0	0%
502 Main	3	3	1	33%
501 Dining room	4	9	1	11%
502 Dining room	5	8	1	13%
501 Dining room	4	5	5	100%
501 Patio	2	3	3	100%
502 Classroom	1	6	6	100%
502 Dining room	4	4	3	75%
Voc-Ed Room 3	2	6	4	67%
Voc-Ed Room 11	1	2	0	0%
Voc-Ed Room 15	2	6	1	17%
Voc-Ed Room 17	3	3	2	67%

#	Provision	Assessment of Status	Compliance

Voc-Ed Room 18	2	4	4	100%
Total percentage of individuals functionally engaged				46%
Percentage of locations with 50% or greater functional engagement				47%

Observations revealed that across all settings, 46% of observed individuals were functionally engaged. Furthermore, seven of 15 settings (47%) of all environments observed reflected at least 50% engagement. These percentages were highly similar to those obtained during the previous site visit (but they were lower than reported by the Facility in the self-assessment, which stated that engagement was provided "during 82% of the time." Such percentages of functional engagement are commendable. Examples of successful functional engagement included the following.

- During lunch on 5/15, staff in the Building 501 dining room made extensive use of prompts and modeling to encourage the use of hand sanitizer.
- On 5/16, staff in the Building 502 classroom demonstrated extensive knowledge of individuals' preferences and learning styles. Individualized positive reinforcement was used extensively.
- On 5/16, staff was observed engaging in animated conversation with individuals regarding personal interests and activities.

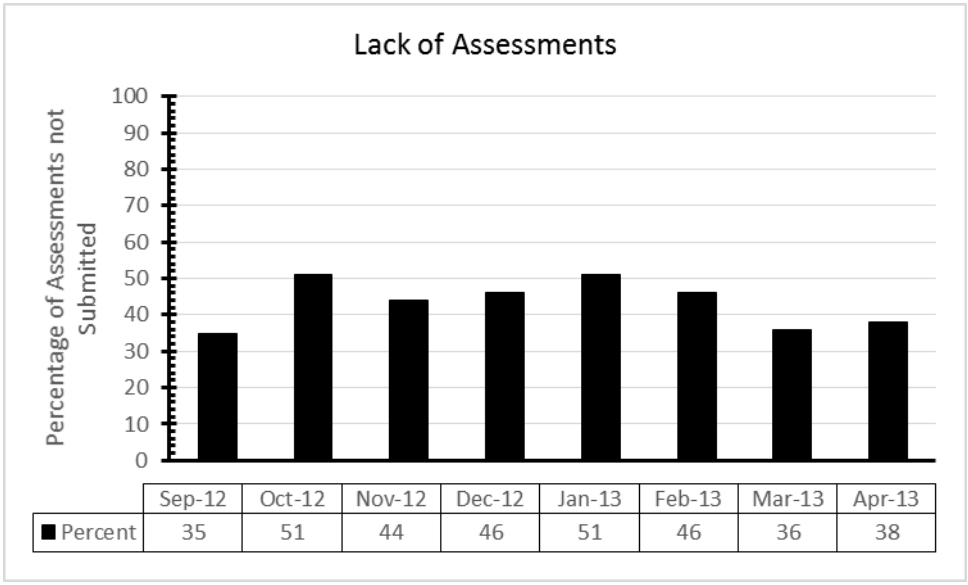
It should be noted, however, that the reported percentages reflected circumstances in which 38 of 70 individuals (54%) were not provided functional engagement. Examples of the lack of functional engagement included the following.

- On 5/16 in Voc-Ed Room 15, one individual was observed engaged with a puzzle. One individual was actively resisting having arms brushed by staff, while four additional individuals sat in chairs without interaction or wandered about the room.
- On 5/16 in Voc-Ed Room 11, no interaction or training was taking place when the Monitor entered the room. Staff hurriedly attempted to set up an activity, but appeared unfamiliar with the materials.
- On 5/14 in the foyer of Building 502, two individuals were observed sleeping while the one staff member present watched a basketball game on television.
- During lunch on 5/14, staff were very slow to serve individuals already seated at the dining tables. Only five people were served in a 15-minute period.

In addition to limitations noted in general functional engagement, staff did not follow written instructions or SAPs in several settings.

- For Individual #101, specific instructions were provided to prompt the individual to eat slowly and swallow between bites. During lunch on 5/15, staff offered no prompts during the observation although the individual was noted to be eating rapidly.

#	Provision	Assessment of Status	Compliance
		• During lunch on 5/15, Individual #12 was observed to yell, jump about, and to bite his hand. Staff were not observed to block the biting behavior, but did repeatedly offer the individual various beverages if he would stop the self-injury, leading to the possibility that they might have reinforced the biting if the beverages were reinforcers for the individual. • Individual #66 was documented as being able to dine independently. On the evening of 5/15, a staff member was observed feeding the individual. Upon enquiry, the staff reported that she was aware the individual could dine independently. As she had been employed at RGSC for only three months, she reported that she had been instructed to feed the individual until she felt comfortable in her job. • Individual #12 was on 1:1 supervision. When observed, the individual was asleep on a sofa next to the assigned staff. Documentation reflected the individual's PBSP and SAPs had not been implemented as scheduled on the day of the observation or the previous day. There were also indications that training data were not frequently monitored. Several individuals had chronic refusals to participate in training documented on data sheets. Other individuals had no data recorded or data were recorded incorrectly for several days. Upon enquiry, staff were unable to explain the lack of accurate data or describe any actions taken by the IDT to address the extensive refusals. • Documentation reflected that Individual #60 had been absent from training since 5/6. • Individual #11 had no documented trials of his SAPs in May. • Individual #98 had no data for his communication program since 5/9. • Documentation sheets for Individual #61 did not include days or dates for numerous trials. • For Individual #5, data sheets reflected no consistency in the number of daily trials conducted. • For Individuals #84 and #77, numerous SLP data sheets reflected annotations describing the lack of data collection since February 2013. • For Individuals #19 and #60, numerous SLP data sheets reflected annotations describing the incorrect data collection since February 2013. Based upon records and observations it was apparent that RGSC had achieved reasonable levels of functional engagement in some areas. Overall, however, the Facility did not demonstrate consistent use of informal and formal teaching. Furthermore, the Facility had not demonstrated the ability to monitor effectively participation in or benefits from skill acquisition training.	

#	Provision	Assessment of Status	Compliance
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	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. For example, according to the documentation provided by the Facility, no vocational assessments had been completed since August 2012. According to documentation provided by RGSC, it was common for the IDT not to receive assessment reports from multiple disciplines. Even during the months in which the Facility achieved the best assessment report submission rates, 35% or greater of all required reports were not submitted to the IDT.  Specific issues related to psychological assessments are presented in Section K of this report. Assessment problems in addition to psychological and behavior assessment were also noted. • The reviewed ISPs did not include specific information regarding adaptive skills. • Very few of the ISPs in the sample included information specific to the SAPs, such as assessment findings or documentation that IDT discussions had encompassed skills targeted by the SAPs. • None of the SAPs included in the sample presented formal assessment of preferences or reinforcers.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• It was not evident that the training steps in the SAPs were individualized or that the task analyses were formulated to reflect individual differences. Because of the broad weaknesses in assessment practices at RGSC, 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.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, 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	An important component of effective skill acquisition plans is that they are based on each individual's needs identified in the Individual Support Plan (ISP), adaptive skill or habilitative assessments, psychological assessment, and individual preference. In other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and represent a documented need. 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.	Noncompliance
	(b) Include to the degree practicable training opportunities in community settings.	At the time of the current site visit, RGSC lacked a system for tracking aggregate data regarding community outings. Individual summary sheets were completed for each outing. These summary sheets indicated the date of each outing and the intended destinations. In addition, each summary listed the individuals that were scheduled to attend the outing and whether each individual did participate. The Facility did not present a system that allowed for more detailed tracking of outings or participants. Furthermore, there were no data on the summary regarding which individuals had SAPs to be implemented in the community or whether any SAPs were implemented.	Noncompliance

#	Provision	Assessment of Status	Compliance
		RGSC did report that 39 individuals had been provided skill acquisition plans that were to be implemented in the community. Due to four individuals having more than one community SAP, the total number of community SAPs was 45. Of these, 37 targeted money management, three programs targeted general exposure to the community, and there was one SAP each that targeted communication, exiting a vehicle, using a seat belt, crossing the street, and physical fitness. The SAPs provided for these 39 individuals did not differ from the SAPs developed for implementation at the Facility, and often were in fact the same program. The only indication that the SAPs were intended for community implementation was the statement that informal training would be provided in the community. No specific schedules for community training were included. Although the Facility provided data forms and progress notes for these SAPs, there was no indication of which data were obtained from community training sessions rather than sessions conducted at the Facility. Based upon available information, there were no indications that community SAPs were based upon the unique needs of the individual or were likely to contribute to the development of skills essential to community living. Furthermore, there were no indications that the Facility had developed and implemented a coherent system for developing, implementing, and tracking community-based training. As a result, it was evident that RGSC had not acted to ensure that each individual was provided with training in the community that appropriately addressed individual needs and preferences.	

	02/2010	08/2012	5/2013
Each individual is provided with training in the community that appropriately addresses his/her needs and preferences.	0%	0%	0%

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

1. It is essential that RGSC ensure that assessments are completed and submitted by each discipline as required for the ISP process. These assessments should be comprehensive, and include instruments and practices accepted by the field or discipline. It is also critical that these assessments provide a valid estimate of the unique strengths and needs of each individual. (Provisions S.1 and S.2)
2. The Facility must act to ensure that the IDT conduct and document a thorough consideration of formal assessments as a part of the ISP process. This process should include an appraisal of the accuracy of all assessments and provide an opportunity for the IDT to request additional assessment. (Provisions S.1 and S.2)
3. A concerted effort should be made to ensure that SAPs are based upon valid and reliable assessment data. Furthermore, the IDT must ensure that SAPs reflect sound teaching methods, adhere to evidence-based practices, and provide a valid and reliable means for tracking the acquisition of skills. (Provisions S.1 and S.3a)
4. When forward- or backward-chaining procedures are selected for SAPs, it is essential that those SAPs are based upon an individualized task

analysis. This includes ensuring that steps reflect the abilities of the individual. (Provisions S.1 and S.3a)

5. Staff tasked with the development of SAPs must possess adequate knowledge of teaching procedures, as well as the skills necessary to develop adequate SAPs. (Provisions S.1 and S.3a)
6. The Facility must act to ensure that levels of engagement and the provision of active treatment is adequate and consistent across all settings. (Provision S.1)
7. It is critical that a system for developing and implementing SAPs for community-based teaching be established. This system should ensure that community-based SAPs are based upon valid assessments, address skills that are practical and functional for each individual, conform to accepted practices for skill acquisition, and include a valid and reliable process for tracking the progress of each individual. (Provision S.3b)

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-Assessment 4/29/13 2. RGSC Action Plan 4/25/13 3. RGSC Section T Presentation Book 4. DADS Policy 004.1 Individual Support Plan Process and attachments (11/20/12) 5. DADS Policy 018.1 Most Integrated Setting (3/31/10) 6. RGSC SOP ICF-MR 200 01 Most Integrated Setting (April 2011) 7. RGSC SOP ICF-MR 600 05 Admissions, Transfers, Furloughs and Discharges (April 2011) 8. Individual Support Plans (ISPs) and Supporting Documentation for Individuals #29, #47, #79, and #101. Documentation requested included: a. The full ISP document, b. All assessments considered during that ISP development process, c. The Personal Focus Assessment, d. MRA CLOIP Assessment Worksheet or most recent Permanency Plan, e. Sign in sheets showing IDT members attending the ISP meeting, f. Any ISP addendums, g. All associated skill acquisition/teaching programs, h. Completed Rights Assessment, and i. Completed Decision-Making Functional Capacity Assessment. j. The last three monthly reviews; k. The last two quarterly reviews; l. Individual's daily schedule; m. Special Considerations list; and n. Third quarterly meeting documentation. 9. For Individual #115, documents relevant to movement and re-admission, including: a. Community Living Discharge Plan (CLDP) b. Admission Packet c. RGSC Mental Health Admission medical and psychiatric evaluations d. MH Multidisciplinary Team Meeting forms of 1/22/13 and 2/4/13 10. For Sample T.1 (Individuals #1, #69, and #141), all completed pre-move and post-move monitoring checklists, including additional documentation that reflects follow-up activity taken by the Facility 11. Meeting notes, meeting between RGSC and Tropical Texas Behavioral Health of 4/19/13 12. Agendas of Area Meetings for Tropical Texas Service Coordination & HCS Providers, with sign-in sheets, for meetings of 9/26/12 and 4/23/13 13. Position description for Transition Specialist 14. Transportation checklist 5/19/13 trip to provider

	15. Referral list for community placement, with date referred, date of transition, and dates of post-move monitoring visits (undated) 16. Status of Referrals table 17. 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 18. 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 19. 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 20. For the past year, a list of all individuals who have died after moving to the community 21. 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 22. A current list of all alleged offenders committed to the facility following court-ordered evaluations 23. For the last twelve months, a list of all individuals who have been assessed for placement, date of assessment, and resulting recommendation(s) 24. 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. 25. Community Living Options Information Process (CLOIP) documentation from Tropical Texas Behavioral Health for 40 individuals for ISP meetings from 9/4/12-5/7/13 26. Minutes of meetings of The Advocates of 9/26/13, 10/2/12, 11/28/12, 1/30/13, 2/27/13, and 3/27/13 27. List of all pre-move and post-move monitoring visits for the last 10 individuals who transitioned from the Facility 28. Section T Monitoring Tools (Settlement Agreement Cross Referenced with ICF-MR Standards) completed for Individuals #29, #47, and #93 29. Training materials and sign-in sheet for training on the Community Transition Process on 1/25/13 30. RGSC Community Placement Report 4/25/13 31. PMM Helpful Hints 050113 **People Interviewed:** 1. Joint interview of Alma Ortiz (Admission/Placement Coordinator), Armando Cobos (Transition Specialist), Rosie Sanchez, QE Coordinator, and Lorraine Hinrichs (ICF-DD Director) 2. Leslie Jaramillo, Tropical Texas Behavioral Health **Meeting Attended/Observations:** 1. ISP Annual Planning Meetings for Individuals #118 and #134
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-

	assessment; and 3) a self-rating. For Section T, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Specifically, the Facility reported data from the Living Options Monitoring Tools and from the CLDP Monitoring Tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: ▪ For several provisions, items from the Living Options Monitoring Tool. For example: • Provision T1a, the Living Options Monitoring Tool items related to encouraging and assisting individuals to move to the most integrated setting. • For Provision T1b1, the Living Options Monitoring Tool items related to individualized protections, individualized services, and individualized supports that need to be provided. • Provision T1c, the CLDP Monitoring Tool o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement for some provisions. o The Self-Assessment inconsistently identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). ▪ The self-assessment stated the sample size reviewed for the Living Options Monitoring Tools was 10 tools. However, it did not identify the population size from which these were selected. Presumably, that was the 44 ISPs that had been completed, but this was not indicated in the self-assessment. ▪ For use of the CLDP Monitoring Tool for provision T1c, the sample reviewed was two CLDPs. Ror the subitems of Provision T1c, the Facility reported on 10 CLDPs. There was no statement of how the selection of two CLDPs had been done (whether that was from the 10 or a different number from which a sample was drawn). o This sample sizes were adequate to consider them representative samples for some provisions (for example, those that reviewed 10 CLDPs) but not for others (for example, for Provision T1c that reviewed two CLDPs). o The Facility did not consistently use the information from the monitoring tools as a consideration in self-rating whether provisions were in compliance. If the Facility is to use staff time and effort to implement the monitoring tools, it should use the data in assessing its status and determining what areas of improvement are needed. Alternatively, if the Facility rates compliance inconsistent with the information from the monitoring tools, it should identify what led to the inconsistency and act to correct that. ▪ For Provision T1a, the information from the monitoring tool reported in the self-

	assessment was that referrals are consistent with the determination of professionals that community placement is appropriate, are not objected to by the individual or LAR, and are consistent with the ISP. Although this information from the monitoring tool was the only information on results provided for this provision, the rationale for a rating of noncompliance was that IDT members continue to need more guidance in identifying supports and protections. While this may be accurate (as noted in the findings of the Monitoring Team), and should be reviewed when doing the self-assessment, it was not reported as a result of this monitoring tool. In fact, a statement that IDT members continue to need more guidance in identifying supports and protections would be inconsistent with the data in the self- assessment for Provision T1b1 that such supports and protections were identified by the IDT. The Monitoring Team is puzzled by this inconsistency, which the Facility should have noted in reviewing its self-assessment. ▪ For Provision T1b1, the information from the monitoring tool stated that 10 out of 10 (100%) revealed that the IDT identified needed protections, services, and supports; the IDT identified services and supports intended to meet the individual's preferences and goals for living in the most integrated appropriate setting; and that there were no obstacles to the individual's movement. However, the Facility rated itself as not in compliance because not all services and supports are being identified for community placement. The Monitoring Team agrees with the finding of noncompliance because it did not find the same results as the Facility did with its monitoring tools (in fact, the very issue noted above for Provision T1a would be inconsistent with the information reported from the monitoring tools for Provision T1b1); nevertheless, the self-rating of noncompliance did not match the data reported. ▪ Used/ other relevant data sources and/or key indicators/outcome measures: o Provided numbers of individuals and LARs/families who participated in the latest provider fair and on tours of community living settings o Provided the number of individuals whose ISP included a living options discussion ▪ The Facility rated itself as being in compliance with the following provisions of Section T: T1b3, T1c, T1c1, T1c2, T1c3, T1d, T1g, T1h, and T2a. The Facility did not assess whether it was in compliance with Provision T2b. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with Provisions T1a, T1h, and T2b but not with the provisions assessed by RGSC as being in compliance. o For Provision T1b3, the Facility accurately stated that the Living Options discussion was held for each individual who "had an ISP." The sample reviewed by the Monitoring Team confirmed that. However, the Facility did not assess whether assessments by professionals included a determination of the appropriateness of movement to a more

	integrated setting. o For Provision T1c and the sub-items of that provision and for Provision T1d, the Facility used information from the CLDP Monitoring Tools to assess compliance. For Provisions T1c, T1c1, and T1c2, the findings of the Monitoring Team review of a sample were not consistent with the findings of the self-assessment sample. For Provision T1c3, the Monitoring Team did not determine whether the specific supports and services were reviewed with the individual and LAR, because two sampled CLDPs did not include the supports and services needed, and therefore could not have been reviewed. For Provision T1d, the Monitoring Team review of a sample found, consistent with the self-assessment, that assessments were timely if done, but that only a limited number of assessments had been completed at all. o For Provision T1g, the self-assessment accurately stated the report had been completed; the Monitoring Team identified concerns with possible issues of accuracy but also had concerns with the DADS report, which is also a requirement of this provision. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as Completed, Completed and Ongoing, or In Process. Many In Process actions appeared actually to be ongoing activities, such as sharing information with the Family Association; it would be useful for the action plan to instead identify specific activities to be done (in this case, for example, implementing a schedule of activities to share information with the Family Association, implementing the schedule, publicizing the availability of the information and the tours, and other steps needed to carry out sharing of information). ▪ The actions did, in part, provide a set of steps likely to lead to compliance with the requirements of this Section. However, it would be useful to identify the steps to implement some actions. For example, regarding policy, the Facility did identify steps required to operationalize revised DADS policy. But for several actions that involve facilitating "individual centered meetings to discuss and document" several requirements, it would be useful to provide a set of activities that would lead toward such facilitation and determine whether it is occurring or needs additional action.
	Summary of Monitor's Assessment: Since the baseline review, RGSC had done an admirable job of changing its whole approach to movement of individuals to more integrated settings. The number of people who moved was remarkable for a facility of this size. Careful planning had permitted successful moves of individuals whose needs were challenging. Continuing improvement in this planning, and greater consistency of this planning across individuals, would make compliance with the requirements of this Section achievable. Not only did a significant percentage of individuals move to more integrated settings, but also the referrals continue. At the same time, observation of ISP planning meetings indicated careful decision-making about the appropriateness of referrals. However, assessments did not consistently include determinations by professions of the appropriateness of community placement; Professionals must assess and make determinations of the appropriateness of movement to more integrated settings and the supports that

	would be needed for successful transition. Outcomes of transitions were generally good. The Facility did not provide information about any adverse outcomes other than one return; it will be important in future visits to have that information. The Facility should carefully review any adverse outcomes to identify means to improve transition and follow-up services or to identify what additional supports the State needs to ensure are in place. As reported in both this Section and Section F, IDTs need to improve greatly their ability to identify protections, supports, and services individuals need in order to progress toward movement to more integrated settings and to succeed in those settings. IDTs must identify, and ISPs must document, obstacles to movement to more integrated settings. IDTs must ensure that any supports identified as obstacles must actually not be available in preferred settings. IDT must improve in identifying a broader range of individualized actions to overcome obstacles. The Facility provides numerous opportunities for education about community living. The Facility should provide individualized plans and document these in ISPs. IDTs continued to need additional instruction as to how to develop an individualized education/awareness strategy for each individual that takes in to account their specific learning needs. The Facility did not consistently list in CLDPs the supports that each individual needs. CLDPs should more clearly identify the evidence that will be needed to show that supports are in place, and the evidence selected should, if present, substantiate the supports are in place. Transition assessments provided to the Monitoring Team were timely, but the Facility needs to ensure that all required assessments are completed. Post-move monitoring visits were timely. Documentation of the visits did not include all required information; for example, documentation did not state the day program sites visited in all cases, and little to no narrative was provided. The post-move monitoring visit observed by the Monitoring Team was comprehensive and thorough.

#	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	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. <u>Policies and Procedures related to Movement to the Most Integrated Appropriate Setting:</u>	Noncompliance

#	Provision	Assessment of Status	Compliance
	to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	DADS Policy 018.1 Most Integrated Settings prescribes 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, 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 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. 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. Transition Outcomes During Last Six Months: • Community Transitions: o Ten individuals transitioned to a more integrated setting (14% of the population at the last compliance visit), and an additional individual was scheduled to move the week following the compliance visit. This was a significant increase compared to the prior review period, and an even greater increase compared to the baseline period, when there were few transitions. This growth in movement was remarkable and demonstrated both a commitment to encouraging and assisting people to live in more integrated settings and effective planning and partnership with the local authority and providers to develop settings. For example, a site was established by a provider to serve four women whose IDTs determined that these women (who had been roommates who got along well together) could be supported and would prefer to live together. In addition, the Facility reported two verbal men had asked to move together, and that occurred. • Referrals for Community Transitions: The Monitoring Team reviewed both the	

#	Provision	Assessment of Status	Compliance
		Community Placement Report dated 4/25/13, a list of "Individuals Referred for Community Placement" provided during the compliance visit, and a Status of Referrals table. o Individuals continued to be added to the referral list. According to a list of referrals provided by the Facility, eight individuals (13% of the population of 63 individuals in residence at the time of this visit) were on the referral list. In addition, during an ISP annual planning meeting observed by the Monitoring Team, a decision was made by the IDT (with agreement by the individual) to begin the referral process for Individual #118. o Four individuals had been referred since the last compliance visit. Of the individuals on the referral list, two had been referred since last compliance visit. In addition, though, two individuals referred since the last compliance visit had moved to a more integrated setting. o Although the number of people currently referred was lower than the number at the time of the visit in August 2012, that was an artifact produced by the number of people who had moved in between visits, which had reduced the number of people remaining on the referral list. o Of the nine referrals listed on the Facility's Community Placement Report, one had actually moved and had returned recently. Of the eight others, four (50%) were referred more than 180 days prior. Of the eight individuals on the list of individuals referred, four (50%) were referred more than 180 days prior; one of these was scheduled to move the following week. o The Status of Referrals table described the tours and pre-placement visits conducted for each individual on the referral list as well as issues identified that delayed visits (such as a bed that was too high for one individual) and actions taken by the Facility to ensure visits were safe (such as having staff of each provider observe enteral feeding prior to a visit). o Individual #115 remained on the Community Placement Report as having an open referral; the individual was not listed on the list of individuals referred. It is important to ensure accuracy of these reports. o The Facility did not provide information on whether there had been any referrals rescinded since the last compliance visit. • <u>Outcomes of Transitions</u> o <u>Returns from Community Living</u>: Except for one individual, all individuals who had moved continued to reside in the setting to which they had moved. ▪ Individual #115 was the only individual who had returned from community living, after nearly a year since movement. The	

#	Provision	Assessment of Status	Compliance
		individual had moved to a community residence and day habilitation site; following an injury during a behavioral episode, the individual moved to his family home. The last compliance report noted that the CLDP did not list several supports that would be assumed to be needed based on the supports being received while living at the Facility and on the assessments, including behavioral supports. Review of documentation provided for two episodes of RGSC mental health facility admission, treatment, and discharge indicated psychiatric evaluation was conducted; the recommendation following the second episode was for behavioral treatment in an ICF-MR. Discharge from the mental health facility was to the ICF-IID program of RGSC. Documentation from the mental health facility reported the individual was discharged to a foster care provider following the first episode. ▪ The Monitoring Team requested minutes of any IDT or other meeting related to responding to issues at placement and of documentation of any review of this case to identify process improvements. No documentation was provided that the Facility conducted an analysis of the discharge and re-admission that might lead to identification of actions the Facility and LA could have taken that might have improved the likelihood of success in community living, or that might lead to improvements in the process of transition planning and follow-up. The Facility reported it conducts a Special Review Team meeting for any return within six months of transition to identify ways to improve the process. The Monitoring Team suggests that the Facility perform analysis (such as root cause analysis) whenever adverse outcomes occur following a move to a more integrated setting, in order to identify ways to improve the process. o <u>Deaths Following Movement to More Integrated Setting</u> ▪ The Facility reported that no individuals had died following movement to a more integrated setting. o <u>Other Adverse Outcomes</u>: In response to a document request prior to the visit for information on whether individuals who had moved experienced any of the following adverse outcomes, the Facility responded that the information would be available on-site. However, no information was provided on adverse outcomes aside from Individual #115. ▪ Psychiatric hospitalizations	

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		▪ Emergency medical hospitalizations ▪ Other <u>Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting:</u> Since the last compliance visit, the Facility had taken or continued a number of actions to encourage and assist individuals to move to the most integrated settings appropriate to their needs. A Transition Specialist funded by the State's Money Follows the Person grant had begun work; this individual had worked for the LA. LA staff, in interview with the Monitoring Team, stated the working relationship between the Transition Specialist and the LA, and the Transition Specialist's knowledge of providers, had contributed to the increase in movement. As reported in Provision T1b2, much has been done to provide education about available community placements to individuals, their families and LARs, and Facility staff, although more needs to be done to develop individualized plans to educate individuals and families/LARs. <u>Determinations of Professionals</u> The Monitoring Team reviewed a sample of ISPs for Individuals #29, #47, #79, and #101. Of these four ISPs, all the assessments for zero of four (0%) individuals included an applicable statement or recommendation about referral to a more integrated setting. • For Individual #29, one of two assessments provided for the documents request (50%) included a determination of the most integrated appropriate setting. • For Individual #47, four of six assessments provided for the documents request (67%) included a determination of the most integrated appropriate setting. One additional assessment included a list of communication and swallowing supports that would be needed if the individual moved but not a determination of the most integrated setting at this time. • For Individual #79, one of three assessments provided for the documents request (33%) included a determination of the most integrated appropriate setting. • For Individual #101, two of six assessments provided for the documents request (33%) included a determination of the most integrated appropriate setting. <u>Conclusion</u> Although, as reported in Provision T1b2, more should be done to develop individualized plans to educate individuals, families/LARs, and staff about available community placements, the increase in movement to more integrated settings made possible through the Facility's emphasis on appropriate movement, the increase in activities to	

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		educate about community living, and the creativity found in seeking settings and situations that meet individuals' preferences, indicate significant progress. Although there was only one return from community living, the Facility needs to ensure that a full review is done whenever there is an adverse outcome, in order to identify means to improve transition planning and ensure needed supports are provided. The Facility did not yet ensure that assessments include determinations of the appropriateness of movement to a more integrated setting. Such determinations set the stage for IDT decisions and for identifying the most integrated setting appropriate for the individual.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	DADS Policy 018.1 Most Integrated Setting, dated 3/31/10, governed transition and discharge processes. However, the Facility reported that a final DADS State Office policy has not been distributed, and the APC reported that it was expected to be finalized in July. As noted in prior reports, the three Monitoring Teams had a number of concerns related to the DADS draft policy. The Facility policy had not changed since the last compliance visit, and the expectation was that Facility policy would be revised to be consistent with the new DADS policy when implemented. The parties agreed that the Monitors would rate T.1.b as just the development of an adequate policy. The sections T.1.b.1 through T.1.b.3 would be considered stand-alone provisions that require implementation independent of T.1.b or any of the other cells under T.1.b. Due to the fact that the State and Facility had not yet finalized an adequate policy related to transition and discharge processes, the Facility remained out of compliance with this provision.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's	<u>Protections, services, and supports</u> The parties and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F1d, F2a1, and F2a3. As noted above in section F of this report, substantial compliance was not found for F1d, F2a1, and F2a3. <u>Obstacles to movement</u> The Monitoring Team attended two ISP annual planning meetings (Individuals #118 and #134) and reviewed four recent ISPs (Individuals #29, #47, #79, and #101) to assess how this process may have affected the IDTs' implementation of this. The IDT determined that referral to a more integrated setting would be appropriate for	Noncompliance

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	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.	one of the two individuals whose annual planning meeting was observed. For the other, the obstacle identified was individual reluctance, and the plan was to tour more integrated settings. There was no discussion of establishing supports and services, including SAPs, that would promote the likelihood of successful movement, or of any other actions that might address the individual's preferences. Of the four ISPs reviewed, two should have had obstacles defined (the other two individual(s) were referred for transition to the community). Of these two ISPs, neither (0%) included an adequate list of obstacles to referral, nor adequate plans to address obstacles. The problems associated with the remaining lists of obstacles included the following: • For Individual #79, the ISP stated that it did not make a recommendation for movement as the individual is fearful of new environments and needs to tour more group homes to become at ease. The IDT recommended tours. There was no evidence of whether there needed to be other supports to reduce anxiety, whether such anxiety was common for the individual in all new situations, or what supports should be provided prior to and during tours in order to minimize anxiety. Furthermore, the living options discussion documented that the individual "gets very anxious when she is ready to get in a van to tour group homes or day habs." Without greater knowledge of the individual, the Monitoring Team cannot judge whether the individual was aware of the purpose of getting in the van at those times, or whether the person becomes anxious whenever needing to get into a van. Therefore, the Monitoring Team could not judge whether additional supports to overcome obstacles should be developed to address transportation issues. The Facility may need to provide further assessment to determine the situations that lead to this anxiety, and whether it relates to a broader anxiety issue or to a preference not to move. Depending on the outcome of the assessment, the Facility might identify supports and take a more assertive approach to overcoming the obstacle. • For Individual #29, the obstacle listed was that the individual's medical needs require access to a nurse at the group home, and there is not a nurse available. There was no evidence to document that there were no appropriate or acceptable homes that would have immediate access to a nurse, nor was there any plan to work with providers to develop such a setting. Although tis would be a responsibility of the Local Authority (LA), the Facility has a responsibility to make that clear and to coordinate with the LA to identify a setting that can provide the needed support or to encourage development of such a setting. <u>Preferences of individuals and LARs</u> Preferences of individuals are determined and described:	

#	Provision	Assessment of Status	Compliance
		• Of the four ISPs reviewed, two (50%) included an adequate description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). However, for the other two, the ISP documented that the IDT could not determine preference but also reported what they had observed that potentially indicated preference. Thus, four of four (100%) included an adequate description of the IDT's review of preference. • Of the two annual ISP meetings observed, the individual's preference for where to live was adequately described in two (100%), and this preference appeared to have been determined in an adequate manner for two (100%). Preferences of LARs are determined and described: • Of the four ISPs reviewed, one individual had a LAR. For that individual, the only information provided was that the LAR was not interested in movement or in being provided informational materials (although the ISP documented that the materials would be provided anyway). • Of the two annual ISP meetings observed, neither individual had an LAR. Training materials and sign-in sheet documented that three QDDPs and three clinical staff received training on the community transition process.	
	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.	<u>Provision of Adequate Education About Available Community Placements to Individuals and Their Families or Guardians to Enable Them to Make Informed Choices:</u> 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: <u>An Individualized Plan For Each Individual</u>: Other than tours of providers (note below), there were not individualized plans for education about available community placements for individuals who were not yet referred for movement. ISPs reviewed for Individuals #29 and #79, and observations of the ISP annual planning meeting for Individual #134 reported the following: • Individual #29 was not referred because the IDT identified a need for "quick access to a nurse that is not available at the group home." No plan was established to identify homes that might have quick access to a nurse or to provide any education about such supports to the individual or family. • For Individual #79, the action plan was to provide tours of community providers. • For Individual #134, although there was extensive discussion (in which the individual answered questions and identified issues that concerned him), the only plan was to arrange tours. Although this was certainly an appropriate plan,	Noncompliance

#	Provision	Assessment of Status	Compliance
		the IDT could have identified how to address the individual's concerns through these tours. An Annual Provider Fair: A provider fair had been held during the prior compliance visit in August 2012. The next fair was scheduled for June 2013. Regular SSLC Meeting With Local Authority (LA): The Monitoring Team interviewed Leslie Jaramillo, representing Tropical Texas, the local authority. Ms. Jaramillo stated that there is good cooperation and teamwork between Tropical Texas and the Facility. Representatives of each conduct tours of community providers together. The Facility provided handwritten notes of a meeting held 4/19/13 between Tropical Texas and the Facility. This included a sign-in sheet listing two Tropical Texas staff, two Facility staff, and the transition specialist. The notes were a list of topics discussed, including needs for crisis stabilization beds, ensuring visits occur as scheduled, and what to do if there are problems with scheduling and completion of trainings of local provider staff by the Facility. In addition, sign-in sheets for area meetings between Tropical Texas and HCS providers on 9/26/12 and 4/23/13 documented attendance by Alma Ortiz, RGSC Admission and Placement Coordinator, and Armando Cobos, Transition Specialist. Education About Community Options: • IDT Action Plans: RGSC did not report information on development of action plans for education about community options. Action plans were not noted in the ISPs reviewed for Section F of this report. The APC reported that there are no skill acquisition plans in place for educating individuals. • CLOIP: The Facility and the Local Authority reported in interview that a CLOIP is conducted with each individual annually. Documentation was provided for 40 individuals, supporting the completion for each individual prior to the ISP annual planning meeting. Some documented clear understanding and expression of preference by individuals, such as for Individuals #15 and #133. Others did not show such understanding or did not express preference, such as Individuals #113 (who moved about a month following the CLOIP). Finally, for others, the LAR did not permit the LA to provide the CLOIP to the individual, or the only information was about LAR understanding, such as for Individuals #3 and #97. In addition, as reported in Provision F1b, a representative of the Local Authority was present for four of four ISP annual planning meetings for which the Monitoring Team reviewed ISP attendance sheets. Tours Of Community Providers: • Opportunities to go on a tour available to all (except those individuals and/or	

#	Provision	Assessment of Status	Compliance
		their LARs who state that they do not want to participate in tours): As an example of documentation of a tour, the Facility provided the Transportation Checklist for a tour to a provider on 5/9/13. The tour took six individuals to "eat lunch with peers who live in the community." The Facility also provided a list of tours from 3/16/12-4/19/13 by individual, date, location, and staff who accompanied the individual, plus an additional list that was untitled but appeared to be overnight visits (two days each) of a total of three visits by two individuals to three different providers. The list of visits listed 17 visits between 11/9/12 and 4/19/13 by 14 individuals (22% of the current population of 63 individuals). In addition, during the ISP annual planning meeting for Individual #134, an action plan was established for tours. The number of individuals participating in tours had remained steady since the last compliance visit, but the total number of tours had declined from 48 visits in six months to 17 visits in the four months reported (it should be noted that the self-assessment reported 21 individuals participated during the six-month period reviewed). Although the percent of individuals going on tours was relatively high, the Monitoring Team did not ascertain whether all individuals had an opportunity to go on a tour unless they or their LARs stated they did not want to participate. • Places chosen to visit are based on individual's specific preferences, needs, etc.: Observation of the ISP annual planning meeting for Individuals #118 and #134 indicated that IDT members made an effort to identify each individual's preferences for more integrated environments as part of choosing places to visit. • Size of tours: In all cases, the visits (other than the tour to eat lunch) involved one individual and were therefore personalized. • Individual's response to tours assessed: The Facility did not provide documentation of a formal system to assess the individual's response. Opportunities Are Provided To Visit Friends Who Live In The Community: As reported above, one such visit had been held the week prior to the compliance visit. According to interview with the APC, she had accompanied the transition Specialist and two DCPs who took six individuals to visit individuals who had recently moved. This was the only example provided; while a good example, it also involved a large number of individuals rather than a smaller number who could enjoy this as a visit to a friend. Also, during the ISP annual meeting for Individual #134, vocational services staff reported the individual had gone on a visit to two people who had moved; the Monitoring Team did not determine whether this individual was one of the six who went to eat lunch with people who had moved, or whether this was an additional visit. It would be good for the Facility to arrange more of these but involve smaller numbers of individuals at each visit. Education Provided In Various Venues: As reported in Section U, RGSC had an active	

#	Provision	Assessment of Status	Compliance
		self-advocacy program, with a significant portion of the population attending most meetings. As reflected in the meeting record for the meeting of 9/26/12, the primary topic for that meeting was Right to Choose where to live. The minutes documented that several individuals identified their preferences of where they would like to live. Some preferred family homes, others preferred group homes, and some preferred continuing to reside at RGSC. The Human Rights Officer "reminded all members that they should continuously strive to have their preferences know to the IDT." This was an excellent example of providing education to individuals. In response to a document request listing all trainings/educational opportunities provided to individuals, families and LARs, this was the only item listed. <u>A Plan For Staff To Learn More About Community Options:</u> DCP staff participated with individuals in all tours of community settings. The Facility did not provide additional information about this except for participation by staff in the Provider Fair. <u>Individuals And Families Who Are Reluctant Have Opportunities To Learn About Success Stories:</u> The APC reported having organized a presentation by a provider at a Parents Association meeting. <u>Conclusion:</u> This provision was found to be not in compliance. The Monitoring Team commends the efforts and progress of the Facility toward promoting education and awareness. Overall, RGSC had carried out several activities but still needs to adequately assess, plan for, and implement a plan for each person's needs for education and awareness, as described in Provisions T1, F1 and F2. IDTs continued to need additional instruction as to how to develop an individualized education/awareness strategy for each individual that takes in to account their specific learning needs. These plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or maintaining relationships with people living and working in the community, and other approaches the Facility might explore and create. All of these provide opportunities for increasing awareness of community living and should be considered in developing an integrated and individualized strategy for each individual. Furthermore, the example of not referring an individual who needed access to nursing indicates Facility staff are not fully aware of the potential for supports to be provided in more integrated environments. Nevertheless, the growth in movement to more integrated settings indicates that individuals, LARs, and staff have all increased their willingness to consider movement to more integrated settings.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least	State and local policies require 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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. This documentation was a summary of the Living Options Discussion during the annual ISP planning meeting. Observation of two such meetings indicated that such discussion was held. At the ISP annual planning meetings for Individuals #118 and #134, the ISP planning guide provided to all IDT members stated which discipline assessments stated the individual's needs could be met in a more integrated environment. During each of these meetings, extensive discussion was held, with participation by the individual, to determine whether a referral should be made. Although the two meetings and the assessments for them showed that the required assessments were made, this was not consistent throughout. The Monitoring Team reviewed a sample of ISPs for Individuals #29, #47, #79, and #101. These showed: • For Individual #29, one of two assessments provided for the documents request (50%) included a determination of the most integrated appropriate setting. • For Individual #47, four of six assessments provided for the documents request (67%) included a determination of the most integrated appropriate setting. One additional assessment included a list of communication and swallowing supports that would be needed if the individual moved but not a determination of the most integrated setting at this time. • For Individual #79, one of three assessments provided for the documents request (33%) included a determination of the most integrated appropriate setting. • For Individual #101, two of six assessments provided for the documents request (33%) included a determination of the most integrated appropriate setting. The presence of recommendations varied across disciplines. OT/PT assessments, for example, regularly made a determination about appropriateness of transition but did not consistently describe the supportive services needed. • Twelve of 12 individuals' OT/PT assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This information was much improved as more detailed requirements were now included as part of the overall determination. • Nine of 12 assessments (75%) provided a statement regarding "Factors for Community Placement" that is detailed and lays out the supportive services needed for successful living. <u>Conclusion</u> There had been much progress in meeting the requirements of this provision. To achieve substantial compliance, assessments will need consistently to document the	

#	Provision	Assessment of Status	Compliance
		determination of the professionals and the supports that would be needed.	
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:	CLDP Policy and Process: 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. Process of Development and Implementation of CLDP: The APC reported that DADS has shortened the CLDP form. CLDPs reviewed for this visit were in the old form, but new CLDPs will use the other form. Per interview, the CLDP process begins with a meeting within three weeks (usually 14 days) following referral; this timeline seems extended, and the Monitoring Team recommends the Facility consider shortening it and beginning the process more quickly. In the past, the APC gathered information from assessments and drafted supports; this has appropriately been changed so that a deadline is provided for the assessments, and the IDT and LA meet to review the assessments. At that time, tours to possible settings and providers are planned and started, with update meetings held to review results of visits and help the individual select the provider. When a provider is selected and a setting chosen, the CLDP meeting is scheduled. To assess compliance with Provision T1c and the subprovision requirements, the Monitoring Team reviewed CLDPs for Sample T.1, three individuals of the last ten who had moved (Individuals #1, #69, and #141). This sample was randomly selected by computer. In addition, the Monitoring Team reviewed the CLDP for Individual #93, for whom a post-move monitoring visit was scheduled during the week of the compliance visit. Note that the Monitoring Team did not have the CLDP for Individual #141 but reviewed the supports listed on the Post Move Monitoring (PMM) checklist. The Facility's self assessment rated this provision to be in substantial compliance, because CLDPs began development when an individual was referred or accepted for community transition, were developed in coordination with the LA, and were individualized to meet the needed supports and services of the individual. This self-assessment reviewed a sample of two CLDPs. The sample reviewed by the Monitoring Team did not produce the same findings. Timeliness of Development and Implementation of CLDP: The Monitoring Team was not able to determine whether the CLDP was developed within three weeks following the decision to refer. For Individual #93, the CLDP was developed several days prior to the ISP annual planning meeting, when determinations	Noncompliance

#	Provision	Assessment of Status	Compliance
		of referral were typically made. Based on review of this sample, CLDPs did not provide adequate statements of the supports that the individual needs. The CLDPs provided by the Facility included the lists of supports needed for two of four individuals (50%) in this sample (Individuals #93 and #141). • The CLDP provided for Individual #1 was partial and did not include the lists of supports needed pre-move and post-move. The Monitoring Team reviewed the supports listed on the pre-move site review document and on the post-move monitoring checklists to identify the needed supports identified by the IDT. • The CLDP for Individual #69 stated: o For Pre-Move supports, "No supports were identified by the team." o For Post-Move supports, "No supports were identified by the team." <u>Development of CLDP in coordination with the Local Authority:</u> All three CLDPs reviewed documented involvement of the LA through signature on the CLDP. In addition, during interview with the LA representative, she stated that she participates in most of the tours of community settings with the individual and APC for individuals on her caseload. A sign-in sheet for the CLDP meeting for Individual #93 documented participation by the LA.	
	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> Interview with the APC and observation of the ISP annual planning meeting for Individual #118 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. At the ISP annual planning meeting for Individual #118, the IDT decided to refer the individual for movement. Discussion was held about support needs, and assignments were made for further assessments to be done. However, the primary action plan was to begin tours to community settings. Plans were also made to address some issues that could affect success, such as participation in day services, which has been problematic. However, these were specific to the individual's services at RGSC, and there were no plans to direct these toward implementation in community settings.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Unlike at the prior compliance visit, though, specific critical support needs were identified at the ISP meeting; these were supports that would guide the selection of homes to tour. Also, it was clear that the responsibility for identification of supports now rested with the IDT (as opposed to the APC being tasked with that responsibility as had been the case at prior visit). This was an improvement. 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. <u>Specification of Procedures to Monitor Presence of Supports</u> 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 each support, the CLDP contained a column for the Evidence, Responsible Person, and Comments/Date Due. Due to lack of supports for two individuals, it was not possible to confirm consistent completion. For Individual #93, this was completed for each support. Evidence for many of the supports was "Visual observation." For some, such as monitoring meals and snacks, referring for an MBSS if change or problems with swallowing, and asking the individual simple questions throughout the day, the evidence was "Copy of employee notes." For these supports, employee notes do not seem to be an adequate means to determine whether the support is being provided. Instead, observation of staff assisting at mealtimes, checking documentation for evidence of changes in swallowing such as pneumonia or choking, and observing individuals interact with the individual would all seem more direct ways to determine whether the support was being provided.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	Because supports were not consistently listed, it is not possible to determine whether responsibility and timeframes were consistently specified. <u>Responsible staff identified for needed actions:</u> For Individual #93, the CLDP identified by name responsible staff from the Facility and the provider. For Individual #1, the Pre-Move Site Visit document also identified by name the responsible staff rom the Facility and the provider. <u>Completion timeframes for needed actions identified</u>: For Individual #93, the CLDP stated that either essential supports required at the time of the transition would be taken at the time of the move, that visual observations had been completed (with a date), or that copies of training signature sheets had been provided. For post-move supports, timeframes simply stated that copies of employee notes would be picked up by the post-move monitor on scheduled visits but did not give timeframes	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>when supports were to be initiated.</td><td></td></tr>
<tr><td></td><td>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.</td><td>Because supports were not consistently listed, it is not possible to determine whether they were consistently reviewed with the individual or LAR. Furthermore, because draft CLDPs were not formally prepared, it was not possible to determine whether the individual and, as appropriate, LAR reviewed the initial CLDP.</td><td>Noncompliance</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>
The PMM reported that she had a tracking system in place to check whether assessments had been provided timely. This was not provided to the Monitoring Team. The Facility did provide the assessments for each individual from the last 10 who moved. The Monitoring Team reviewed those for Individuals #1, #69, and #93. 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>#1</td><td>5</td><td>5</td><td>100%</td></tr>
<tr><td>#69</td><td>4</td><td>4</td><td>100%</td></tr>
<tr><td>#93</td><td>7</td><td>7</td><td>100%</td></tr>
</table>
* All assessments provided with the CLDP were. Any identified as not completed were not found in the assessments provided.

Although assessments were timely, some assessments were not included in the materials provided. For Individual #1, there was no nutrition assessment, nor was there a psychiatry assessment although the individual was prescribed a psychotropic medication. For Individual #69, there was no OT/PT or communication assessment. The Facility must ensure that all necessary assessments are completed.

<u>Adequacy and Comprehensiveness of Assessments:</u>
The Monitoring Team did not specifically address the comprehensiveness of the assessments. Issues raised in other sections of this report document need for improvement in assessments, with improvement noted in some discipline 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 transition to a more integrated setting.</td><td>Noncompliance</td></tr>
<tr><td>T1e</td><td>Each Facility shall verify, through the MRA or by other means, that</td><td><u>Local Authority Continuity of Care Process:</u>
As part of the document request, the Monitoring Team asked for a list of all pre-move and</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
	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.	post-move monitoring visits, and completed checklists for the last 10 individuals who moved to the community. The Monitoring Team reviewed the documents provided for Individuals #1, #69, #93, and #141. The Facility provided pre-move documents completed by the LA for zero of four (0%). <u>Pre-Move Site Visit Completed by Facility:</u> 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 assess compliance. The Monitoring Team reviewed pre-move site reviews conducted by the APC for four of the individuals who had moved (Individuals #1, #69, #93, and #141). For three of four (75%), the Facility provided a pre-move checklist. • For Individual #1, the checklist documented the date of visit. The only documentation of findings was that the day following the visit was documented in the column "Comments/Date due." There was no way to determine whether that meant that the evidence had been found for each essential pre-move support. • For Individual #93, all pre-move supports were documented as found. • For Individual #141, there were two issues: o A positive finding was that the monitor noted there was no walk-in shower. She took action to ensure the shower was provided. It was documented as observed at the 7-day post move monitoring visit. o Evidence for the pre-move essential support of awake staff was listed as "visual observation"; the comment column noted that the provider director stated there will be awake staff. Although this might be an appropriate way to check, it did not match the evidence that the monitor was supposed to check. Although the Facility monitor found all supports in place or took appropriate action (assuming the documentation for Individual #1 meant supports were found in place), this process continues to be limited by the comprehensiveness and clarity of the lists of supports needed. The lack of documentation for one individual, and the lack of clarity in the documentation for one individual, result in a finding of noncompliance.	
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	<u>Quality Assurance Processes Related to Planning for Review of Living Options</u> The Facility provided completed monitoring tools for living option review for 40 individuals. No summary documents or trend data were provided, so the Monitoring Team could not determine how the information from these tools was used for planning. The Facility did not provide information on whether there is assessment of interobserver agreement to ensure ratings are accurate. The Facility should determine how	Noncompliance

#	Provision	Assessment of Status	Compliance
	plans for which the Facility is responsible, consistent with the provisions of this Section T.	information from these tools is to be used, as the monitoring process requires a significant resource investment. Information could be used for coaching IDT members, but it is also possible some information could be included in a quality assurance system to identify issues and practices that need to be addressed. <u>Quality Assurance Processes to Ensure Development of CLDPs:</u> Responsibility for ensuring CLDPs were complete and comprehensive, and that assessments were completed, fell to the APC. The APC reported that she now tracks completion of pre-move assessments; the Monitoring Team did not review the tracking system, and the Facility did not provide data, but review of documentation showed that assessments that had been completed were done timely. The Facility needs to implement more formal processes to monitor and ensure development of CLDPs, especially in regard to comprehensiveness of the lists of supports. <u>Quality Assurance Processes to Ensure Implementation of CLDPs:</u> 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. 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. The Facility continued a process of having a quality assurance observer accompany the APC when she did post-move monitoring visits. In addition, the Transition Specialist reported accompanying the APC on these monitoring visits. 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	<u>Facility Annual Obstacles Report:</u> The Facility provided an updated Annual Report: Obstacles to Community Transition, Rio Grande State Center, Fiscal Year 2012 for review. RGSC reported that, for FY 2012, LAR reluctance for alternate placement was indicated as an obstacle for the largest number of individuals (22 individuals). Another significant barrier was lack of funding due to an individual's legal and citizenship status (eight individuals). In response to a document request for a printout of the database/report summarizing the obstacles identified for individuals' movement to the most integrated appropriate setting, the Facility replied, "Family Preference." Although that was an accurate representation of the most common obstacle, it did not provide a comprehensive listing or any indication of an ongoing data tracking process.	Noncompliance

#	Provision	Assessment of Status	Compliance
	assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	In response to a request for a list of all individuals who have not been referred solely due to LAR preference (i.e., whether or not the individual himself or herself requested placement), the Facility simply replied "No changes since last visit"; this did not provide information needed to determine the consistency of Facility information with the obstacles report. In its action plan, the Facility reported that entering "data into obstacles database" was "In Process" but this database was not presented to the Monitoring Team for review. Furthermore, the Community Placement Report dated 4/25/13 reported for " Individuals Prefers Community—Not Referred—LAR Choice" that no individual fell into this category; although that may be due to lack of clarity of an individual's preference and thus might be accurate, the large number of individuals for whom LAR preference is a barrier would indicate at least the possibility that there are individuals who would fit into this category. Additional Action Plans were devised to reduce individual and LAR reluctance for alternate placement, to ensure successful placements and reduce the numbers of rescinded referrals. Having accurate and meaningful data as a result of the first Action Plan will allow the Facility to develop more focused Action Plans in the future. <u>DADS Annual Obstacles Report:</u> DADS had also issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. The report was issued to the Monitors and DOJ on 2/26/13, six months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 13 obstacle areas used in FY12. DADS indicated it would continue working with the Facilities in relation to the annual reporting of obstacles to transition. Such technical assistance is needed given the continuing problems with data collection discussed below. • There was some effort to separate a review of obstacles to referral from a review of obstacles to transition once an individual was referred. • DADS included a list of 12 initiatives it was continuing to support. In general, these efforts were in the early stages of implementation and/or were ongoing activities related to Section T as well as other sections of the Settlement Agreement (e.g., revisions to the ISP process). • The report included attachments with each of the Facilities' annual reports. The following concerns were noted with regard to the report: • <u>Definitions</u>: Section T.1.b.1 of the Settlement Agreement required that the Facility "identify the major obstacles to individuals' movement to the most integrated setting consistent with the individual's needs and preferences at least annually." The State's report, however, defined obstacles "as issues, barriers, or	

#	Provision	Assessment of Status	Compliance
		impediments that delay an individual from moving to a service delivery setting of his/her choice. These include any supports not currently available to meet the needs and preferences of the individual in the alternate setting." This definition does not seem to adequately capture those issues, barriers or impediments that could prevent an individual from making a choice of a more integrated setting, including a lack of awareness on the part of the individual or LAR or LAR reluctance. These are frequently identified obstacles to individuals' movement to the most integrated setting, and the data in the report reflect that this is so. • Referrals: As indicated on page 3, if a team did not refer an individual for transition, then an obstacle to a referral should be identified. However, generally, the numbers of obstacles to referrals were much lower than they should have been given the limited numbers of referrals at each of the Facilities. o It appeared Facilities had interpreted Table 4 differently. In some instances, data were provided for the list of obstacles for all individuals for whom they had data, regardless of whether the individual's preference was to transition to the community. In other instances, it appeared these data were for the subgroup of individuals who had expressed an interest in transition, but their guardians were reluctant to consider it. Both sets of information were important, but the reports certainly should have included the data on obstacles to referral for all individuals the Facilities supported. • Transitions: Surprisingly, adequate methodologies were not in place to collect data on obstacles to transition. As a result, the validity of the data provided in the report was questionable. • Data: It was concerning that valid and complete data were not available. In addition, the plans included in the Facility reports often did not describe specific actions that would be taken to make improvements with the data. For example, for many of the SSLCs, the plan to improve data collection involved retraining QDDPs and IDTs, as well as using a new data system. This was presented in general terms, and it was unclear if it was based on an analysis to determine the underlying causes for teams not properly identifying obstacles to referral and/or transition. • Assessment: The Facility-specific reports generally did not provide the "comprehensive assessment" the Settlement Agreement required. They merely stated the data with little to no analysis of the data. Beyond some minimal descriptions of often vague actions the Facilities would take, the reports offered no recommendations to DADS with regard to issues that went beyond the capacity of the Facilities to address, and for which DADS' intervention was needed.	

#	Provision	Assessment of Status	Compliance
		• DADS initiatives: DADS included a list of initiatives; however, these initiatives did not address many of the obstacles that the Facilities had identified. For example, according to the 2012 Annual Obstacle Report Data spreadsheet, 112 individuals were not referred due to "Behavioral health/psychiatric needs requiring continuous monitoring/intervention," and 100 individuals faced a "Lack of supports for people with significant challenging behaviors." Similarly, 54 individuals were not referred due to "medical issues requiring 24-hour nursing interventions/services," and 92 individuals faced a "Lack of availability of specialized medical supports." Even without full data, it was clear that these two areas required attention. However, beyond general statement about maximizing use of available funding and "Engaging local authorities and private providers in joint discussions on how to enhance provider capacity to meet the characteristics of those individuals transitioning from the SSLCs to community placement settings," the report provided no indication of the specific steps, if any, the State was taking "to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs…" • Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS).	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live	The Facility provided a Community Placement Report covering 9/1/12-3/31/13. The report listed: • Current referrals: Nine individuals were listed as open referrals. Individual #115 had moved prior to the last compliance visit and returned since that visit; the individual continued to be referred for movement, and the list retained the referral date from prior to the individual's move. • Community placements: 10 individuals were listed as having moved since the last visit, all in 2013. • Rescinded referrals: No individuals had rescinded referrals during this period. This would be a significant improvement compared to FY 2012, for which the obstacles report indicated five rescinded referrals. For the report from the last compliance visit (which would have been during FY 2012), two rescinded referrals were reported. • Individuals prefers community—Not referred—LAR Choice: No individuals were in this category. • Individual prefers community—Not referred—other reasons: Three individuals were in this category, one for legal issues and the other two for citizenship/funding issues. • LAR prefers community—not referred: No individuals were in this category.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	The Monitoring Team asked that a final category be added that includes a list of names of individuals who would be referred by the team except for the objection of the LAR whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. As noted above with regard to Provision T.1.a of the Settlement Agreement, professionals on individuals' teams need to make independent recommendations regarding the appropriateness of an individual for community placement. This category was not yet found in the report. Conclusion: This provision was found to be in substantial compliance. The report was made in a timely fashion. As a stand-alone document, it still did not fairly represent the relatively large number of individuals who were not referred due to LAR choice regardless of the preference of the individual, but the Facility and State's intention was to gather and report this information.	
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	To evaluate post-move monitoring, the Monitoring Team reviewed the list of individuals who had moved, a list of all pre-move and post-move monitoring visits for the last 10 individuals who transitioned from the Facility, and all pre-move and post-move monitoring visit information for Sample T.1. To provide opportunity for PMM visits to have occurred, this sample was selected by computer randomization from the nine individuals who had moved between 1/11/13 and 3/25/13. In addition to this sample, the same materials were reviewed for Individual #93; the Monitoring Team accompanied the PMM on the 45-day post-move monitoring visit for that individual. Staffing Alma Ortiz, Admission/Placement Coordinator, conducted post-move monitoring. Since the last compliance visit, a Transition Specialist had been assigned to the Facility. Per interview and documentation on post-move monitoring checklists, the Transition Specialist participated routinely in post-move monitoring. Timeliness of post-move monitoring visits: According to the list of PMM visits conducted for the 10 individuals who had moved between 1/11/13 and 4/19/13, 21 reviews should have been completed. Of the 21 required visits, 21 (100%) were conducted and 21 (100%) were completed on time. The Monitoring Team reviewed documentation of post-move monitoring provided by the	Noncompliance

#	Provision	Assessment of Status	Compliance
	is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	Facility plus the one visit that occurred during the compliance visit. • For Individual #141, all three PMM visits were timely. • For Individual #1, RGSC provided only the 7-day and 45-day PMM checklists; neither was dated, but the list of PMM visits reported the date, which was timely. The 90-day visit was not due at the time the document was provided. • For Individual #69, RGSC provided only the 7-day visit checklist; it was not dated, but the list of PMM visits reported the date, which was timely. The 90-day visit was not yet due. • For Individual #93, the 7-day report was the only one due, and it was timely. The 45-day visit was conducted timely during the compliance visit. <u>Locations visited</u>: For the seven post-move monitoring visits reviewed, the PMM checklist documented all of the sites at which the individual lived and worked/day activity (e.g., day program, employment, public school) were visited during five (71%). • For Individual #1, all sites were visited during all PMM visits, but there was not a statement of what day habilitation or vocational site was reviewed, as required by the form. • For Individual #1, this was documented for the 7-day visit but not for the 45-day visit. There was not a statement of what day habilitation or vocational site was reviewed, as required by the form. • For Individual #69, the Individual was not yet participating in a day service site, so only the home was visited. • For Individual #93, this was not documented for the 7-day visit. The Monitoring Team accompanied the PMM reviewers to both the day site and home for the 30-45 day visit. <u>Content of review/completed checklists</u>: For the seven post-move monitoring visits reviewed, two (28%) of the post-move monitoring reviews were documented in the proper format. • For Individual #1, the 7-day visit listed the evidence reviewed but left blank the evidence to be reviewed. For the 45-day visit, the evidence to be reviewed was listed, but there was no documentation of the evidence actually reviewed. • For Individual #69, the one checklist reviewed was completed in the proper format. • For Individual #141, there was not statement of the habilitation/vocational site visited. • DADS re-implemented use of a PMM checklist format that had been used earlier in the settlement agreement compliance process. This was used for the PMM visit for Individual #93 and was completed in the proper format.	

#	Provision	Assessment of Status	Compliance
		Findings of PMM checklists consisted almost entirely of yes/no checks of the presence of supports and services. Detail/comment was not included regarding the evidence the Post-Move Monitor reviewed to confirm the existence of the pre- and post-move supports. There was no detail, such as by indication of the evidence examined, other than the checkmark that the support was present along with either a description of the evidence examined or the evidence to be examined (but without detail of what actually was found). For some supports, such as presence of a walk-in shower, that may be acceptable. For some supports, such as a monitoring form to show that staff will communicate with the individual and referred to communication strategies recommended by RGSC, it would be good to have a brief explanation of how the PMM review of the form was done, and some sort of information such as how often monitoring was conducted, and whether there had been corrective actions identified as needed. Zero (0%) of the post-move monitoring report forms identified need for follow-up. Therefore, for zero of the individuals for whom post-move monitoring reviews were conducted, additional follow-up, assertive action, and activities were required of the post-move monitor. For Individual #93, the use of the Settlement Agreement's Appendix C post move monitoring form was reinstated. The Monitoring Form reviewed the PMM checklist in light of a document provided by DADS that gives Helpful Hints guidelines to the facilities. The checklist did not fully comply with these guidelines. • The guidelines require a comment about whether medications are properly secured and whether medication administration records are available and complete. The checklist for Individual #93 did not comment on these. • The guidelines require documentation to confirm staff have been trained, including whether staff can identify the individual's diet/texture. The checklist for Individual #93 did not comment on this. • The guidelines require the checklist to always include a comment from the PMM, including a brief narrative of observations, in reporting the finding of whether the individual expresses satisfaction with his/her new life. The checklist for Individual #93 did not comment on this. • The form did not require, and the checklist did not state, which sites were visited during the PMM visit. The guidelines require that all location be visited but do not require these be reported. Furthermore, the Monitoring Team could not determine what evidence the PMM was to look for and what evidence the PMM examined to "assess whether supports called for in the CLDP are in place." It was therefore impossible to determine if the Facility was	

#	Provision	Assessment of Status	Compliance
		substantially complying with this requirement.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	The Monitoring Team accompanied the APC, the Transition Specialist, and the Quality Assurance director on PMM visit. Visits were made to the residence and to the day habilitation site. The PMM reviewed each support listed on the PMM checklist. The PMM did ask questions, as required by the Helpful Hints guidelines, regarding use of a communication book and how choices are offered throughout the day. She reviewed an initial evaluation by a speech language pathologist (SLP) about swallowing and was informed the SLP will meet with staff monthly. She checked to determine whether an adapted utensil was present at the day habilitation site; it was not, and staff reported it had been left at the house. She checked when visiting the house, and she found it was not present there, either. The Monitoring Team did not review the checklist completed by the APC. The Post-Move Monitoring Visit was made to both the home and day program site. The review was comprehensive and checked each support listed. The monitor followed up on the statement about the utensil, discovered it was inaccurate, and requested action.	Substantial Compliance
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	The Facility stated no individuals were alleged offenders committed follow court-ordered evaluations.	Not rated
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the	In response to a document request of a list of all individuals who have been discharged pursuant to an alternative discharge, the Facility responded "None."	Not rated

#	Provision	Assessment of Status	Compliance
	provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.		

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

1. Perform and document analysis (such as root cause analysis) whenever adverse outcomes occur following a move to a more integrated setting (including return to the Facility), in order to identify ways to improve the process or to identify what additional supports the State needs to ensure are in place. Include determination of whether assessments identified all issues that could have contributed to the return. (Provision T1a)
2. Develop a process to document response of individuals during tours of community settings and to provide that information to the IDT. (Provision T1b2)
3. The CLDP should be drafted at the time of referral, including supports needed, and updated on an ongoing basis. (Provisions T1c and T1c1)

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-Assessment 4/29/13 2. RGSC Action Plan 4/25/13 3. RGSC Section U Presentation Book 4. DADS Policy 019: Guardianship, effective 3/7/12 5. RGSC Standard Operating Procedure (SOP) ICF-IID 200 04 Process for Reviewing the Need for Guardianship, April 2012 6. RGSC SOP ICF-IID 200 09 Self Advocacy Program—The "Advocates" July 2012 7. Need for Guardianship Record 4/10/13 and 5/15/13 8. Training roster for Need for Guardianship 4/10/13 9. List of individuals who have renewed or attained guardianship 10. Contact Log (list of guardianship and self-advocacy activities) 2/19/13-4/18/13 11. Rights assessment racking sheet 12. HRC Referral Tracker 13. JCAHO Ethics, Rights & Responsibilities Team minutes of 4/17/13 and agenda for 5/15/13 14. Minutes of meetings of The Advocates of 10/2/12, 11/28/12, 1/30/13, 2/27/13, and 3/27/13 **People Interviewed:** 1. Vanessa Alvarez, Human Rights Officer (HRO) **Meeting Attended/Observations:** 1. ISP Annual Planning Meetings for Individuals #118 and #134 2. Pre-ISP Planning Meeting for Individual #48 3. The Advocates (Self-Advocacy group) meeting of 5/15/13 4. JCAHO Ethics, Rights & Responsibilities Team 5/15/13
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section U. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section U, in conducting its self-assessment, the Facility: • Did not use monitoring/auditing tools but did use other relevant data sources. Data were provided on number of individuals reviewed for Guardianship Priority during annual staffings as well as the number for whom potential guardianship resources were available. The Self-Assessment also provided data on number of individuals with renewed or newly established guardianships and the number of individuals who participated in Arc of Texas training on self-advocacy and rights. • The Facility rated itself as being in compliance with neither of the two provisions of Section U. This was consistent with the Monitoring Team's findings

	The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. • Actions were reported as including, for Provision U1, operationalizing policies, updating the guardianship priority list, and establishing both a competency tool to assess capacity and a tool to assist and prompt the IDT during ISPs in discussing an individual's ability to consent. For Provision U2, actions included taking steps to reduce financial obstacles to guardianship, assisting in completion of documents needed for guardianship, recruiting guardians, and facilitating self-advocacy. For each of these topics, there were both standalone activities and activities for which a set of sequential steps was listed. A few actions were reported as completed, but most were in process (as would be expected from an action plan). • The Facility data identified areas of need/improvement. The Action Plan addressed areas of identified need. For example, the Self-Assessment identified the need to assess individuals' capacity, and the Action Plan included steps to establish a competency tool, train IDTs on implementation, and monitor ISP discussions. The Self-Assessment identified the need for more individuals to have guardians established, and the Action Plan included a number of steps to recruit guardians and facilitate establishment of guardianships. • The actions provided a set of steps likely to lead to compliance with the requirements of this Section.
	Summary of Monitor's Assessment: The HRO at the time of the last compliance visit had left the Facility, and there was a brief gap until a new HRO began. The new HRO has continued the initiatives implemented by the prior HRO. The Facility updated the guardianship priority list and continued its active self-advocacy program. The Facility documented a significant number of individuals as being in need of guardianship. **Provision U1:** The Facility maintained, and updated 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. The list was prioritized according to criteria as described in policy, but the determination of need was not predicated on a standardized process or tool, nor was there any other indication of an organized and comprehensive approach to identify whether individuals actually did not have functional capacity to render a decision. **Provision U2:** The Facility continued to make significant efforts to develop guardianships as appropriate and to facilitate the process of establishing guardianship. The Facility identified 63% of individuals as being in need of guardianship. The Facility has taken a number of actions to both establish guardianships and to assist individuals in advocating for themselves. Continuing effort will be needed to meet the requirements of this provision. The Facility must continue to be creative and look for additional ways to establish needed guardianships and identify individuals for whom other options are appropriate. The Facility had assigned the role of Guardianship Committee to an existing committee. The Facility should ensure the membership of this committee matches the requirements of statewide policy. The Human Rights Officer has been providing training to this committee about guardianship.

	The Facility had continued to promote a self-advocacy program that had active participation by a large number of individuals. Structured training is provided at each meeting on an area of rights, and there is routine discussion of reporting abuse and neglect at most meetings. In addition, the Facility had worked with the Arc and another agency to present training sessions on self-advocacy to individuals residing at RGSC and to community advocates and was working to schedule additional sessions. Overall compliance with Section U will require 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> DADS issued Policy 019: Guardianship in March 2012; 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. 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. The policy addresses 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 states the IDT would prioritize the guardianship list but also assigns responsibility	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. 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. 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): ▪ 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. ▪ Appointed the HRO to be the Guardianship Coordinator, as required by Policy 019. ▪ Established the Joint Commission Ethics, Rights, and Responsibilities Team to be the Guardianship Committee. ▪ Requires that the priority list be updated by the HRO at least semiannually and after any significant health change, 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. However, as noted below, the Guardianship Committee requested additional information be provided on the guardianship list, indicating the committee provided review.	

#	Provision	Assessment of Status	Compliance
		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 nor did it include a statement of who should be on the Guardianship Committee. <u>Development and Maintenance of Prioritized List:</u> The Facility maintained a prioritized list, using prioritization ratings from Priority I (most in need) to Priority III (least in need) and Non-priority (individuals with guardians). This list was developed by a workgroup that included the ICF-IID HRO (who chaired the group), the four QDDPs, the QDDP Coordinator, and the Director of Quality Assurance. The HRO reported that discussion of priority for guardianship occurs during each ISP annual planning meeting; she also reported attending two ISP annual planning meetings per month to observe and assist with that discussion. Semiannually, the guardianship list is updated. The last update done by this group was 4/11/13. The Facility provided the most recent updated list from that meeting. Following that meeting, the list was updated 5/15/13 to reflect a new guardianship; this indicated the Facility's ability to maintain and update the list, and is a positive finding. The 5/15/13 revision also color-coded the individuals whose barriers to guardianship included either a need for financial assistance or non-citizenship. <u>Assessment of Functional Capacity to Render a Decision</u> 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 reported in the Action Plan contacting the Austin SSLC regarding status of establishing a competency tool. The HRO discussed alternative tools with the Monitoring Team; the Monitoring Team recommended presenting these to DADS and keeping DADS informed of any planning being done. As noted in the last compliance report, this continuing effort to identify useful and appropriate measures was commendable. Observation of discussion of capacity to consent during the two ISP annual planning meetings held during the compliance visit provided mixed findings. At the meeting for Individual #118, there was no discussion of capacity, simply a quick agreement that the individual could not provide consent in any area, without any rationale or other information provided. For Individual #134, however, there was not only extensive discussion but also acceptance of the individual's decisions on medical treatment, and on whether to refer to move to a more integrated setting (and where would be preferable).	

#	Provision	Assessment of Status	Compliance
		However, there was no discussion of capacity, nor any indication of assessment using validated instruments; the discussion did reveal that the IDT members were familiar with the individual's prior decisions in these areas and ability to articulate them. Even so, there was no discussion during the review of restrictions (for which most items had no restriction). The Monitoring Team also observed the Human Rights Committee meeting during the visit. The Committee was presented with several rights restrictions, and these restrictions were discussed in depth, but there was no discussion of or questions pertaining to informed consent. Conclusion: The Facility maintained, and updated 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. The list was prioritized according to criteria as described in policy, but the determination of need was not predicated on a standardized process or tool, nor was there any other indication of an organized and comprehensive approach to identify whether individuals actually did not have functional capacity to render a decision.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	<u>Policies and Procedures related to obtaining LARs for individuals in need:</u> DADS Policy 019, issued in March 2012, had remained unchanged; RGSC SOP ICF-IID 200-04 had been revised in April 2012. No change had occurred since then in the procedures related to obtaining LARs. These policies list the responsibilities of the State Center to solicit and provide guidance on how to become a guardian to LARs of other individuals, families of individuals lacking LARs, correspondents of individuals lacking LARs, advocacy organizations, and other entities seeking to advance the rights of individuals with disabilities. In addition, they include as duties of the HRO: ▪ Providing information to the State Center's Parent/Family Association members regarding alternatives to guardianship and local guardianship programs and resources; ▪ Sharing appropriate information regarding individuals in need of a guardian with local guardianship programs as permitted by law; ▪ Soliciting information from local guardianship programs regarding community supports available to assist with guardianship fees, court costs, and other expenses; and, ▪ 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Establishment of a Guardianship Committee As noted above, the Facility established the Joint Commission Ethics, Rights, and Responsibilities Team to be the Guardianship Committee. The Monitoring Team reviewed the minutes of this committee for 4/17/13 and attended the portions of the 5/15/13 meeting relevant to guardianship. 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" as stated in the policy under the responsibility of the Guardianship Coordinator to establish the committee. Based on minutes of the 4/17/13 meeting and observation of the meeting during the compliance visit, membership of the committee included only Facility staff (although several of those members were from the mental health program and the outpatient clinic program areas of the Facility). No LARs interested family members, or correspondents of individuals served, individuals receiving services at the facility, or impartial members of the community participated in this committee. At the committee meeting observed by the Monitoring Team, the HRO did recommend adding to the committee an individual served in the ICF program at the Facility and recommended an individual. She also recommended adding an LAR or advocate. The committee agreed to both of these recommendations. At this meeting, the HRO provided training on guardianship for individuals with intellectual disabilities. As part of the training, she encouraged the members to ask questions, and there were several questions asked and answered. Minutes of the April 2013 meeting included documentation that the HRO presented summarizing February and March information on self-advocacy meetings, self-advocacy training provided by the Arc of Texas and Educare to individuals living at RGSC as well as to individuals living in local communities, and an event to engage residents in the voting process for self-advocacy committee officers. It was apparent that the committee is beginning to take an active role in assisting in the improvement of guardianship and self-advocacy activities. Efforts to Obtain LARs: Based on review of a list of new guardianships attained provided by the Facility in response to a document request, and review of the Need for Guardianship Record of 4/10/13 compared to that of 5/15/13, the Facility had obtained guardians (LARs) for 11 individuals since 10/5/13. Ten of these were renewals of guardianships for individuals	

#	Provision	Assessment of Status	Compliance
		whose guardianships had expired. The HRO reported there were 11 renewed and one new guardianship; this slight discrepancy may have been due to the gap in dates between the completion of the document request and the development of the 4/10/13 list. This was an increase in renewals compared to the last compliance visit. As of the Need for Guardianship list of 5/15/13, 39 individuals were in need of guardianship of 62 individuals at the Facility (63%); the remainder had guardians. This assumes that all individuals without guardians require a guardian. The use of a validated measure of capacity to consent, along with the development of advocacy and other processes to provide assistance with decision-making, might reduce the number of individuals who require a guardian. The Facility was making efforts to obtain LARs. o The Facility continued to make efforts to work with an attorney and judge to provide pro bono assistance and to reduce the cost to file guardianship applications. Although this continued to be a difficult process, the HRO reported two members of the Guardianship Committee had suggested doing the same in a neighboring county and were planning to make contacts. o The HRO provided a copy of a log of contacts for guardianship (list of guardianship and self-advocacy activities) for the period of 2/19/13-4/18/13. The beginning date was the date the HRO began her duties. The log included a range of activities, including guardianship renewals; information about self-advocacy meetings, training, and activities; emails to counties; speaking to the RGSC Parents Association head to arrange to do a presentation regarding self-advocacy, and Guardianship Committee meetings. o The HRO reported that the training from the Arc about self-advocacy was also intended to assist in recruitment of community people to serve as advocates. o The HRO reported that she attended DADS training on guardianship and human rights committee. HRC has decided to have training at the end of each HRC weekly meeting. This will include issues of guardianship. <u>Self-Advocacy</u> 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	

#	Provision	Assessment of Status	Compliance
		DADS policy, essentially repeating it and providing a name for the groups ("The Advocates). 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. Meeting observed and review of minutes: The Monitoring Team observed the meeting of The Advocates on 5/15/13. As with the meeting during the last compliance visit, this was well attended, and it involved active participation by many individuals. One improvement was that The Advocates now had a full slate of officers, and the HRO assisted the president to run the meeting. There was an organized agenda, including a power point presentation and prompting of active involvement regarding freedom of choice and identifying preferred activities. A brief discussion of reporting abuse was also held; the HRO stated this is done at every meeting. Minutes for meetings held since the last compliance visit suggest a similar practice occurred at each meeting. The Monitoring Team reviewed minutes from five meetings of The Advocates; each included an organize discussion of a right (with slides used). Four of five (80%) included discussion of abuse and neglect. The Contact Log reported the HRO coordinated with the Arc of Texas and Educare to schedule another Self-Advocacy Training, this one regarding employment. The Facility did not provide information on the sessions already held, other than a statement in the Self-Assessment that three trainings had been help for 10 individuals who reside at RGSC. This is an excellent opportunity for training from someone outside the Facility staff to individuals who reside at the Facility. It might also serve to maintain a relationship with an agency that might be able to assist in gaining guardianship or increasing the availability of advocates for individuals who may not need guardianship but do need assistance in decision-making. Conclusion: The Facility continued to make significant efforts to develop guardianships as appropriate and to facilitate the process of establishing guardianship. Continuing effort will be needed to meet the requirements of this provision, and the Monitoring Team encourages the Facility to continue to be creative and look for additional ways to establish needed guardianships and identify individuals for whom other options are appropriate.	

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

1. The actual responsibilities of the Guardianship Committee under DADS Policy 019: Guardianship should be clarified. (Provisions U1 and U2)
2. The Facility must ensure the composition of the assigned Guardianship committee meets the requirements of Policy 019 for the Guardianship Committee. (Provision 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. The Facility should keep DADS informed of any planning or actions it undertakes in this regard. (Provision U1)
5. The Facility should consider building on the self-advocacy training by Arc and Educare 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. (Provision U2)

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-Assessment 4/29/13 2. RGSC Action Plan 4/25/13 3. Presentation Book for Section V 4. Recordkeeping Policies 5. DADS Policy 020.1 Recordkeeping Practices 3/05/10 6. RGSC SOP HIM400-02-ICF Additions, Updates and Changes to the Unified Record 10/4/12 7. RGSC SOP HIM 400-07-ICF Documentation Guidelines revised 2/25/13 8. RGSC SOP HIM 400 14-ICF Filing and Purging of Information Policy/Procedure revised 7/17/12, reviewed 2/4/13 9. RGSC SOP HIM400-15-ICF ICF-DD Transcription of Clinical Assessments 3/26/13 10. RGSC SOP HIM400-18-ICF Coding Diagnosis' 4/8/13 and attachments 11. RGSC SOP HIM 400-20-ICF ICF-DD Monthly Record Review 2/27/13 and attachments 12. RGSC SOP HIM 400-21 ICF Completion of V4 Interview/Observation Tool 4/4/13 13. List of new or updated Facility policies since last compliance visit 14. DADS Policy 009.1 Medical Care 9/6/12 15. RGSC Standard Operating Procedure (SOP) ICF-IID 400 17 Consultation Request Process 1/30/13 16. RGSC SOP QM 100.14 DADS Quality Assurance Expectations (2/13) 17. RGSC SOP HR 100-07 Compliance With Required Training/Performance Evaluations/Corrective Action Plans/Health Information Management Deficiencies Requiring Action (2/13) 18. Training rosters for SOP 400-17 Consultation Request Process 19. List of persons responsible for management of records 20. List of persons responsible for auditing of records 21. New Employee Orientation (NEO) RGSC Unified Record presentation materials 22. Table of Contents of Active Record 3/25/13 23. Table of Contents of Individual Notebook 8/20/12 24. Table of Contents Master Record 7/30/12 25. Instructions for Use of the Active Record Audit Tool 4/17/13 26. HIM Deficiencies Requiring Action blank form 5/31/12 27. Use of Active Record Check-Out Form blank 5/8/13 28. Use of Active Record Check-Out Form Audit April 2013 29. Use of Active Record Check-Out Form Audits March 2013 and April 2013 30. Training rosters for ICF Documentation March 2013 31. Revision to ICF Documentation Guidelines (HIM training) 32. Documentation Training for ICF 3/15/13 33. Record Audit Tools for March 2013 audits (Individuals #51, #29, #79, #97,and #114) and April 2013 (Individuals #93, #47, #11, #82 including Interrater reliability audit report, and #66) 34. Deficiencies Requiring Action Report 5/10/13 Health Information Management (HIM) items

	35. March 2013 ICF Delinquency Report 36. HIM Deficiencies Requiring Action (DRAs) for audits completed in March 2013 (report dated 4/16/13 identifying cleared items) and cover email of 3/12/13 from Melissa Canales to clinicians, QDDPs, and management staff 37. Follow up email of 3/19/13 requesting documentation of completion of corrections required in DRAs list 38. HIM DRAs Closed (completed and cleared) list of 4/16/13 39. Active Record and Deficiencies Requiring Action report for Individual #66 40. Active Record, Individual Notebook (Residential) and Master Record for Individuals #33 and #115 41. Printout of posted assessments for Individual #118 42. Settlement Agreement Provision V.4-Observation for Use of the Record completed forms for Individuals #3 (4/9/13), #66 (3/19/13), #51 (2/18/13), #5 (1/24/13), #84 (12/14/12), and #21 (11/1/12) 43. Settlement Agreement Provision V.4—Observation for use of the Record completed forms for observations of ISP annual planning meetings of 11/1/12 (Individual #21), 12/14/12 (Individual #84), 124/13 (Individual #5), 2/18/13 (Individual #51), 3/19/13 (Individual #66), and 4/9/13 (Individual #3) **People Interviewed:** 1. Leticia Gonzalez, RHIT, Health Information Management (HIM) Director, and Melissa Canales, RHIT, Unified Records Coordinator (URC) 2. QDDPs Daniel Perez and Rebecca Olivarez 3. Mary Ramos, Quality Management Director, Lorraine Hinrichs, ICF-IID Program Director, and Leticia Gonzalez, RHIT, Health Information Management (HIM) Director, joint interview regarding policy development **Meeting Attended/Observations:** 1. ISP Annual Planning Meetings for Individuals #118 and #134 2. Pre-ISP Planning Meeting for Individual #48 3. Records storage areas at La Paloma, El Paisano, and HIM
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section V. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section V, in conducting its self-assessment, the Facility: ▪ Used a variety of monitoring/auditing tools. Tools included the statewide interview tool for use of the record as well as RGSC-specific record audit tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: ▪ The Active Record Audit Check-Out Form ▪ An audit tool that listed Appendix D requirements, updated 3/1/13

	▪ The V4 Observation Tool; however, the Self-Assessment did not provide information from use of this tool. ▪ The staff interview tool for use of the record o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The Self-Assessment identified the sample(s) sizes, but did not include the number of individuals/records/meetings reviewed in comparison with the number of individuals/records in the overall population or the number of meetings held that might have been observed. The number of interview tools for use of the record sent out and returned were both reported. This sample sizes were adequate to consider them representative samples. o The records audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The staff/positions responsible for completing the audit tools were not provided in the Self-Assessment. However, based on interviews and review of documents for this compliance visit, these were the following: ▪ For audits of record, the Unified Records Coordinator (URC) ▪ For observations of meetings, the staff completing this tool were not specified, but completed forms documented review by the URC. ▪ For the Active Record Audit Check-Out Form, the URC and HIM outpatient clinic supervisor o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the record audit tool. ▪ The record audit tool provided the only data used in the Self-Assessment. The Active Record Audit Check-Out Form was new and had not been used at the time of the Self-Assessment. No data were provided for the observation tool. The only data provided for the staff interview tool were for number of interview tools sent out and number returned, but no data were reported for the responses to the tool. Finally, although the CAP and Deficiencies Requiring Action process could provide data on whether corrections were being made to records (the primary barrier to achieving substantial compliance with Provision V3), this issue was not reported as being assessed. ▪ The Facility presented data from the record audits in a meaningful/useful way; data were not presented for the check-out audits or observation of meetings. Specifically, the Facility's Self Assessment: o Presented data by each item of Appendix D requirements measured. o Presented data presence of the components of the Unified Record as well as for compliance with each specific requirement of Appendix D measured. However, data were not presented on presence of documents separately from whether the records met Appendix D requirements. This is especially important as the lack of presence of required documents was the greatest barrier to compliance with Provision V1. o All audits were done by the HIM department, which both did all filing of documents and also served as the Quality Assurance review for the check-out audits and the meeting observations.

	▪ The Facility rated itself as being in compliance with the no provisions of Section V. This was consistent with the Monitoring Team's findings The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as Complete or In Process. ▪ The Facility data identified areas of need/improvement, but not all assessment items provided data yet. Nonetheless, the Action Plans were appropriately separated by areas needing action (for example, one area of Provision V4 related to analyzing the interview responses, and another area related to observations of meetings. ▪ The actions provided a set of steps likely to lead to compliance with the requirements of this Section. Three of the areas included a step of providing data to SA-PIC for analysis—and appropriate action—but did not indicate that the analyses would lead to actions. Nevertheless, actions contained enough detail to have the potential for effective planning and action.
	Summary of Monitor's Assessment: The Facility continued to make progress in all areas of this Section. A unified record was maintained, and use of information from the records was improving. There was continued development of policies needed to meet the requirements of the Settlement Agreement. The Facility maintained a Unified Record for each individual. Active Records, Individual Notebooks ("Me Books"), and the Master Record were both accessible and secure. The records in the Clinical Work Station were accessible to designated staff, but the process continued to be cumbersome and 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. Training on documentation was provided both in new employee orientation and in refresher training. Review of records by the Monitoring Team found inconsistency in completeness of the Active Record and Individual Notebook; however, the sample was small (two records). Data provided by the Facility also showed some level of inconsistency, although audits showed records were generally complete. The major issue of lack of complete records involved late assessments, consistent with information provided throughout the Sections of this report. The Facility had a robust audit system in place that audited all records annually (and a minimum of five per month), identified items requiring correction, tracked corrections and provided reminders until completion, and ensured items that were reported as completed actually had been completed. Two areas of improvement are needed for compliance. First, attention must be paid to items from audits of individual records that remain in need of completion for extended times. Second, the Facility should identify issues

	needing systemic improvement and implement effective actions. Staff were able to describe how they used records in decision-making and planning services and supports. Both observations by the Monitoring Team and data provided from facility observations of ISP annual planning meetings indicated use of records for decision-making during those meetings was inconsistent. Data and documents in addition to assessments were not always entered timely. When this occurred, it limited the usefulness of such information for planning and decision-making. Many statewide and facility protocols and procedures required to implement the Settlement Agreement have been revised as needed; however, some essential protocols and procedures remain to be developed and implemented. 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. 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.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	<u>Policies Governing Recordkeeping</u> The Facility had a number of policies to maintain a Unified Record with the required components. • RGSC SOP HIM 400-07 ICF Documentation Guidelines guides documentation practices. This policy 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 clarify that crossing out gaps in lines or spaces in documents referred only to handwritten entries, not typed documents. • RGSC SOP HIM 400-02-ICF addressed specifically ICF requirements for the process to make additions, updates, or changes to the records. It was revised to clarify the steps in additions, updates, or changes to the CWS. • RGSC SOP HIM 400-14 Filing and Purging of Information Policy/Procedure governed (as the title states) how filing and purging are to be done; this policy was revised to require identification or job title. • RGSC SOP HIM 400-15-ICF guides the transcription of clinical assessments and notice to physicians of reports and notes pending. • RGSC SOP HIM 400-18-ICF provides instructions for entering diagnoses into the CWS. • 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		was revised regarding inter-rater compliance reviews and requirements for Deficiencies Requiring Action notices. Facility policies were consistent with DADS policy. <u>Maintenance of a Unified Record for Each Individual</u> The Facility maintained a Unified Record for each individual. The unified record at RGSC consisted of an active record, individual notebook (the Me Book, separated by Residential and Vocational), Master Record, Overflow (which remains in the Master Record until the retention period is completed), and the Clinical Work Station (CWS). 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. 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 and 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. The Monitoring Team audited the Active Record and Individual Notebook ("Me Book") for Individuals #33 and #115, and reviewed the Master Record for both these individuals. For both individuals, all three components of the Unified Record were readily accessible. The Monitoring Team also looked for the Active Record, Individual Notebook (Residential), and Master Record for Individuals #27, #29, #55, #79, and #101. These five individuals represented the four living units. Including Individuals #33 and #115, for seven of seven individuals (100%), all components of the Unified Record were available. <u>Accessibility and Security of Records</u> Active records were kept in a locked room in each of the two living units. Home staff were able to access the records as needed. A checkout list was in each room with the active records. Individual records were kept at the residential and vocational sites and were usually easily accessible. 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	

#	Provision	Assessment of Status	Compliance
		to individuals who should not have access. As noted above, records were present and accessible. The Facility had an effective process for checkout/check-in of Active Records. Two of two observations in El Paisano and La Paloma living units found the checkout book present. All charts not present were documented as checked out, and no charts remained checked out were present. The check-out lists were completely accurate (100%). The Facility performed a monthly audit of the check-out process. The audit for April 2013 documented for each volume of the Active Record and Individual Notebook whether it was present or not; the form provided to the Monitoring Team was undated, and there were several individuals for whom an volume was not present but neither "Yes" or "No" was marked under the column "Chart Checked Out" and the boxes for total of records not found filed and for records not checked out were marked "0." This audit is an excellent tool, and could be effective if completed and if it results in follow-up actions, either individual or systemic, as needed. <u>Clinical Work Station</u> Documentation in the CWS was, of course, legible and readable. Records were accessible to designated staff but the process continued to be cumbersome. Integrated Progress Notes (IPNs) were available by discipline, but there was no easy way to compare IPNs from different disciplines for a specific issue. This 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. Some documents, such as some physician documentation, was printed so that a hard copy could be kept in the Active Record for easy access. <u>Training of Staff on Documentation</u> The Facility provided competency-based training to staff who document in the Unified Record. The Facility provided training during New Employee Orientation (NEO). The Monitoring Team was provided the training materials, but there was no evidence provided of competency testing. In addition, the Facility provided refresher training on documentation during March 2013. <u>Accuracy and Completeness of Records</u> To determine whether Active Records were completed in compliance with Facility policy and Appendix D of the Settlement Agreement, the Monitoring Team reviewed the complete Active Record and the Individual Notebook (Residential) for Individual #33 (selected through computer randomization from among the records to be audited in April 2013) and Individual #115 (selected from among the individuals who had been	

#	Provision	Assessment of Status	Compliance
		admitted since the last compliance visit), as well as the last 10 audits conducted by the Facility in March and April 2013 and included in the document request. The Monitoring Team checked for the presence of each item on the Active Record Order & Maintenance Guidelines (AROG) for Individuals #33 and #115. To do this, the Monitoring Team used the Active Record Audit tool 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 order per guidelines." Many documents were 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/Skill Acquisition Plan would be in the appropriate section of the record. For Individual #33, 75 documents were present in the Active Record and Individual Notebook, seven required documents were not present, and 48 documents were not applicable. Therefore, 75 of 82 documents that should have been in the Active Record (91%) were found in it (a figure consistent with the percentages reported in the Trends Report for the past 13 months). A visual scan of the audits conducted in March and April 2013 indicated a similar percentage present. For Appendix D requirements, 98 items were compliant, and 14 were not, for a percent compliant of 88%. However, for Individual #115 (for whom the Monitoring Team audited only the Active Record), the percentages were lower. Thirty-five documents were present in the Active Record, and 10 required documents were not present, with 72 documents not applicable (the higher number of not applicable due, in part, to timelines for required documents not having been met since admission—some annual or quarterly documents, for example). Therefore, 35 of 45 documents that should have been in the Active Record (78%) were found in it. For Appendix D requirements, 53 items were compliant, and 12 were not, for a percent compliant of 79%. Although the percentages of documents present approached an acceptable level, some critical documents were not present. The ISP was not found in the record, nor was the Positive Behavior Support Plan (PBSP), nor were skill acquisition plans. These are essential elements needed for providing consistent treatment, and they need to be available to IDT members and staff who implement treatments and interventions. For both individuals, the Appendix D requirement most often missed was whether documents were "current, complete, and in correct order per guidelines." Only a few other instances were found of other noncompliances. Improvement since the last	

#	Provision	Assessment of Status	Compliance
		compliance visit was most notable regarding gaps between handwritten entries. One concern remained, though that was not listed on the audit tool--initial legends for items that could be initialed were not present in the records. As one example, Universal Signature Sheets in the Medication Administration Record Notebooks for nurses responsible for administering medications were not updated when nurses leave or when new nurses were added. Most of the nurses' signatures, titles, and initials were illegible. It is essential that the Universal Signature Sheets are kept up-to-date and that the nurses' signatures, titles, and initials are legible. The Facility provided trends data for the 14 months beginning March 2012 through March 2013. Data from Facility audits over the past six months documented compliance from 78% in December 2012 and February 2013 to 91% in March 2013. Four of six months had reported compliance of 80% or above. This overall compliance score did not differentiate presence of documents from consistency with Appendix D requirements. Moreover, a bar graph of data on timeliness of assessments indicated several assessments that were not current in the record in audits over several months. <u>Use of Share Drive</u> QDDPs demonstrated use of the Share Drive for posting and availability of assessments by PST members. The QDDP identified the required assessments. Per RGSC SOP 600 01, assessments are to be posted to the Share Drive 10 days prior to the annual PSP meeting for an individual. 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 #118, identified which assessments were posted, and read them. Not all required reports were present, as reported in Provision F1c. <u>Conclusion</u> The Facility has come very close to substantial compliance and continues to progress. The Unified Record contained all required components. Active records were in good condition, with almost all required documents present for most individual records and few errors when compared to Appendix D requirements. For one recent admission, the percent of documents current and present was close to an acceptable level, but the specific documents missing were troubling. The Facility should consider closer monitoring of records of recently admitted individuals. The greatest obstacle to compliance was the delays in completing assessments, which cannot be filed in the record unless they are complete.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof	<u>Facility Process to Develop and Revise Policies</u> A Facility process existed and was followed to develop and revise policies, protocols, and procedures; this process required periodic review and revision as needed. Per interview	Noncompliance

#	Provision	Assessment of Status	Compliance
	and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	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 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 Sharepoint folder 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. <u>Training on Policies</u> The Facility had a process to identify what type of training is needed on new and revised policies (but not to identify what competencies must be trained, if any), and to ensure and document that training was provided. This process was not written in a policy or procedure but was described during interview. The system included: • What categories of staff need to be trained. • Who will be responsible for certifying that staff who need to be trained have successfully completed training, The system did not include: • What type of training will be required (e.g., notice only, notice with written acknowledgement of requirements, classroom training, review of materials, competency demonstration), • Who will be responsible for developing training and any needed competency tests, • What documentation will be necessary to confirm that such training has occurred, and • A timeframe or due date for completion of initial training (including whether training will be done immediately or incorporated into annual or refresher training, or both). 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	

#	Provision	Assessment of Status	Compliance
		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 policy itself states the staff positions the policy applies to. Review of policies found that this listing often included all ICF-IID staff; the Monitoring Team reviewed training rosters for SOP 400-17 Consultation Request Process (for which all IDF-IID staff were to be trained), which did include a wide range of positions and appeared comprehensive. In addition, the Monitoring Team reviewed training materials and sign-in sheets on documentation, as reported in Provision V1; this training covered documentation policies and procedures and was presented by HIM staff for consistency, and sign-in sheets indicated a wide range of staff were trained. The Monitoring Team did not review whether there was a process to track training and ensure that all staff for whom a policy was applicable completed training. This will be reviewed at future visits. However, the Quality Assurance Director and Director of ICF-IID reported that each new or revised policy becomes an agenda item for SA-PIC and remains till 100% of applicable staff are trained, indicating a process existed. Training compliance for "Consultations" was, indeed, listed on the SA-PIC agenda for 5/14/13 but no information was provided in the packet of materials for that meeting. The Facility did not describe 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, what sort of training must be completed and what specifically must be included in the training, who will provide training, and who has been trained. 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. <u>Development and Revision of</u> <u>Policies to Implement Part II of the Settlement Agreement</u> There is evidence that many protocols and procedures required to implement Part II of the Settlement Agreement have been revised as needed; however, some essential protocols and procedures remain to be developed and implemented.	

#	Provision	Assessment of Status	Compliance
		New and Revised Policies: The Facility and State had developed or revised policies necessary to implement Part II of the Settlement Agreement since the last compliance visit. The Facility provided in its Self-Assessment a list of policies implemented since the last compliance visit. These were: • ISP Monthly Review • ICF-IID 700-13 Levels of Supervision • RGSC Policy ICF-IID 400 17 Consultation Request Process had been implemented in January 2013 to guide the consultation process. This comprehensive policy covers the major issues of consultation. The Monitoring Team determined additional policies and procedures had been developed or revised, including: • DADS Policy 009.1 Medical Care 9/6/12 • RGSC SOP HIM400-15-ICF ICF-DD Transcription of Clinical Assessments 3/26/13 • RGSC SOP HIM400-18-ICF Coding Diagnosis' 4/8/13 and attachments • RGSC SOP HIM 400-20-ICF ICF-DD Monthly Record Review 2/27/13 and attachments • RGSC SOP HIM 400-21 ICF Completion of V4 Interview/Observation Tool 4/4/13 • RGSC Standard Operating Procedure (SOP) ICF-IID 400 17 Consultation Request Process 1/30/13 • RGSC SOP QM 100.14 DADS Quality Assurance Expectations (2/13) • RGSC SOP HR 100-07 Compliance With Required Training/Performance Evaluations/Corrective Action Plans/Health Information Management Deficiencies Requiring Action (2/13) Areas in Which Efforts Are Needed • A Facility policy and/or procedures did not exist that describes the monitoring system for the communication provision of the ISP for individuals who would benefit from AAC. • As reported in Provision O1, the Facility did not have a comprehensive PNM policy. • The Facility did not have a comprehensive OT/PT policy. 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	

#	Provision	Assessment of Status	Compliance
		implementation, including the ISP and restraint policies, as well as to complete others that remain in draft form or have not yet been developed.	
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.	<u>Audit Policy and Process</u> RGSC had a process in place to audit records. SOP HIM 400-20-ICF provided the procedure that included the process for completion of the audit on the audit tool, verification of findings through inter-rater compliance reviews (with documentation of any changes arising from these reviews to be put on the Instruction Sheet for Use of the Active Record Audit Tool), a one-week timeline to submit deficiencies requiring action, and reporting of results. The policy described selection of records for audit as being selected from the annual staffing list for the month reviewed; although this is not a random selection process, reviewing all records for which an annual staffing was held provides audit of 100% of records annually, which is acceptable. The Facility Self-Assessment reported that a minimum of five and maximum of nine records had been audited each month from July 2012 through February 2013. The HIM Director stated the practice is to audit the record for every individual who had a staffing the prior month. If there were not five staffings, they would audit the record for an individual who had a staffing in the current month and would ordinarily be audited the next month. The Monitoring Team compared the list of individuals who had ISP annual planning meetings during February and March 2013 to the audits provided by the Facility for March and April 2013. Individual #44 did have an ISP annual meeting in March 2013 but did not have an audit in April 2013 or (per report following the visit) in May 2013. The Facility did not provide evidence that the selection of five individual (of the six who had ISP annual meetings in March 2013) was random. Five audits were completed monthly in March 2013 and April 2013. Audits were done of all charts in the Active Record and of the Individual Notebook. The HIM Director stated there are no other components of the Unified Record except the Master Record. <u>Interobserver Agreement/Interrater Reliability</u> The Facility had a process for evaluating interobserver agreement on audit findings for each audited component of the Unified Record. From the five audits, the Facility selected one record for audit. Because the HIM staff did the filing and purging, the Facility assigned a records management staff from the Facility's outpatient clinic (a separate part of the Facility with separate records) to do an independent audit; this began in March 2013.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The HIM Director reported that an interobserver agreement check is done for one record per month. That would represent 20% of the required five audits per month. Using this process, an audit was done for Individual #82's active record, but not the Individual Notebook. The Facility provided an audit tool for each of the three charts of the active record. For each item, the ratings by the auditor and the independent reviewer were entered under the Yes, No, or N/A column. This permitted calculation of an overall agreement percentage but also allowed a visual check to see which specific items were not in agreement. Although the Facility provided no formal process to check specific items over time to see if there was consistency in which had disagreements, the small number of auditors makes it at least possible that such a trend would be noticed. The Facility should develop a process to identify whether there are items for which disagreement is common so better definitions or other means to improve agreement are implemented. For the active record for Individual #82, agreement was found for chart 1 on 76 of 97 items reviewed (78%), for chart 2 on 54 of 77 items reviewed (70%), and for chart 3 on 71 items out of 83 items reviewed (86%). Although these approach acceptable agreement, overall agreement did not reach the criterion of 80% that would ordinarily be considered acceptable. Furthermore, there was no differentiation on agreement regarding presence of documents versus on Appendix D requirements, which could be useful information to know. Other than this one example, the Facility did not provide data on findings from reliability audits. As a check to determine whether the definitions and guidelines provided adequate information to permit another rater to agree, the Monitoring Team selected one record (for Individual #33) by computer randomization from among those selected by the Facility for an audit in May. No training was provided other than the guidelines and the Instructions for Use of the Active Record Audit Tool. The Monitoring Team and URC completed the audit of the Active Record and the Individual Notebook—Residential independently on the same day; the Monitoring Team was not able to complete the Individual Notebook-Vocational, so no information is available about agreement on that document. The table below reports the findings:	

Chart	Documents present A/D	Documents present % of agreement	Appendix D requirements A/D	Appendix D % of agreement	Total % of agreement

#	Provision	Assessment of Status	Compliance

Active 1	32/7	82%	52/8	87%	85%
Active 2	26/3	97%	34/14	71%	78%
Active 3	45/3	94%	38/10	79%	88%
Individual	16/2	89%	23/7	77%	81%
Total	119/15	89%	147/39	79%	83%

A=agree
D=disagree

Overall, agreement fell within an acceptable range. Clearly, agreement was better on the presence of documents than on whether Appendix D requirements were met. However, even agreement on whether Appendix D requirements were met was only slightly under the 80% usually considered acceptable. The Facility should consider working with DADS to clarify definitions and criteria for the tool.

Audit Findings

RGSC provided trend data that could be used to review and assess status of the Unified Record. Trend data were provided for a 12-month period. The March 2013 ICF Delinquency Report included:

- Graph of monthly chart audit compliance score from March 2012 through March 2013. Scores ranged from lows in December 2012 and February 2013 of 78% to 93% in March 2012, April 2012, and August 2012. The compliance score for March 2013 was 91%.
- Graph of compliance percentages by month for nine disciplines/areas
- Graph of assessments under 90% by discipline by month
- Tables and graphs of ICF Telephone Order Audit

Corrective Actions

The Facility had a process to take corrective actions for specific deficiencies identified in audits of individual records, ensure corrective actions were completed, and track deficiencies to determine trends that require systemic action. RGSC SOP HR 100-07 includes procedures for HIM deficiencies requiring action. Included was a statement that staff assigned to complete required assessments for an individual's record who do not meet the deadline for completion of a delinquent assessment will have the Positive Performance Management program initiated. It also states that it "is the immediate supervisor's responsibility to ensure that all employees under the supervisor complete all delinquent HIM Deficiencies Requiring Action by the date in which they are due. If the Deficiency Requiring Action is not completed by the assigned due date for completion, a 'Performance Counseling will be given to that employee." The policy continues with further actions if the deficiency continues not to be corrected. This places the responsibility for document production with the individuals responsible for providing

#	Provision	Assessment of Status	Compliance
		them and with their supervisors. The Monitoring Team did not request, and the Facility did not provide, any documentation that verified this policy was being followed and actions taken. The Deficiencies Requiring Action Report of 5/10/13 listed items identified as missing, not current, or needing correction that had not yet been corrected. Although many of these items were from recent audits, original due dates for corrections not yet completed were as early as 2011. The Facility should clear those corrections no longer needed because the documents would not be current and should ensure currently-needed corrections are completed as required by policy. Most corrections involve lack of current assessments. Simply having a policy is not adequate; implementation of the policy is necessary. The Facility provided the corrective actions required and completed for the March 2013 audits, as well as the open (uncorrected) actions required since 2011. For the audits completed in March 2013, corrective actions were required for all deficiencies identified for five of five audits (100%). The Facility followed up assigned corrective actions until completed, but this follow up continued for extended periods without actual completion of the actions. Although many of the items were cleared, the DRA report of 5/10/13 documented completion of all required actions for 0 of five (0%) records audited in March 2013. Along with the items on that report that were long overdue, this finding indicates the Facility needs to implement processes to ensure that items needing correction are not only identified but are also corrected. To ensure reports of completed corrective actions were accurate, HIM staff reported they checked the corrections that were reported before clearing them. The Monitoring Team selected the record of Individual #66 by computer randomization from the audits conducted in April 2013 and accompanied the URC to review the active record. All items reported as cleared were in place, and no items reported as not yet cleared were in the record. Items not cleared were on the DRA list of 5/10/13 as still needing correction. <u>Review of Trends and Use of Audit Information for Systemic Improvement</u> Findings of audits were included in the Facility's regular QA process for evaluating status and making decisions about corrective and improvement actions. As noted above, trends data were provided to the monthly SA-PIC meeting. Although the information documented several disciplines that frequently did not provide assessments timely for the record, the Facility did not provide evidence of systemic action taken to address this. However, the Facility had taken action to address trends identified in following Appendix D requirements by revising training and providing refresher training in March 2013.	

#	Provision	Assessment of Status	Compliance
		Conclusion The Facility had a robust audit system in place that audited all records annually (and a minimum of five per month), identified items requiring correction, tracked corrections and provided reminders until completion, and ensured items that were reported as completed actually had been completed. Two areas of improvement are needed for compliance. First, attention must be paid to items from audits of individual records that remain in need of completion for extended times. Second, the Facility should identify issues needing systemic improvement and implement effective 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. Records are Accessible to Staff, Clinicians, and Others As reported in Provision V1, Active Records and Individual Notebooks (Residential) were readily accessible. To get Individual Notebooks, the Monitoring Team asked residential staff to provide them; this was done in all cases (100%) immediately with no difficulty in finding them. However, there were difficulties in gathering information for clinical decision-making and use of health care plan instructions by DSPs, as reported in Provision M1. • 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. • As was found in previous reviews, the Facility did not include health care plans instruction sheets for direct support professionals in individuals' Individual Notebooks because they did not have a record number. It is essential that the Individual Notebooks include health care plan instruction sheets for the direct support professional to follow in providing care. In addition, the Share Drive made assessments readily available to clinical staff, residential directors, QDDPs, and others who might need to refer to them. The CWS made accessible IPNs and certain assessments, but, as noted above, the process to review those could be somewhat cumbersome. However, the Monitoring Team observed that although records were accessible, they were not always used in delivering services and supports. For example: • As reported in Provision F1d, assessment information was not consistently used in making decisions during ISP annual planning meetings.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• As reported in Provision O4, staff were observed not implementing interventions and recommendations outlined in the PNMP and/or Dining Plan. <u>Documents are Filed in the Record Timely and Accurately</u> As reported in Provision V1, data from Facility audits over the past six months documented compliance from 78% in December 2012 and February 2013 to 91% in March 2013. Four of six months had reported compliance of 80% or above. This overall compliance score did not differentiate presence of documents from consistency with Appendix D requirements, so it is not possible for the Monitoring Team to determine the percent of documents filed timely. However, a bar graph of data on timeliness of assessments indicated several assessments that were not current in the record in audits over several months. Audits of the Active Records for Individuals #33 and #115 and the Individual Notebook (Residential) for Individual #33 showed that documents were generally present for Individual #33, but the percent of documents present was lower for Individual #115; for Individual #115, several essential documents needed for providing consistent treatment were not present. Assessments were not consistently completed in time for the information to be reviewed by IDT members prior to the ISP annual planning meeting. The Facility provided an ISP assessments tracking log monthly report for ISPs from September 2012-March 2013. The tracking log provided the percent of assessments completed and the percent timely by department each month. Percentages of timely completion ranged from 15% in February 2013 to 32% in November 2013. As one check on current status of assessments, the Monitoring Team asked a QDDP to look on the Share Drive for an individual who had an ISP annual planning meeting scheduled within 10 business days. The QDDP selected Individual #118, whose meeting was to be held the next day. Several assessments were not yet posted. The Monitoring Team requested a printout of the assessment report for this individual. Review of the printout found the following: • Of 21 assessments due, 17 (81%) were completed by the due date 10 days prior to the ISP annual planning meeting. Assessments not completed timely were the Medical Assessment, Dental Assessment, Rights Assessment, and Water Safety Assessment. <u>Data are documented/recorded timely on data and tracking sheets</u> Data were not consistently documented and recorded timely. For example: • As reported in Provision M5, although there was a database to track bowel elimination, there were wide gaps with no bowel eliminations reported. If these data were used, there should have been timely follow-up; however, there was no	

#	Provision	Assessment of Status	Compliance
		indication the information on bowel eliminations was used for decision-making. • Several examples were reported in Provision S1 of the lack of recording data for Skill Acquisition Plans (SAPs). Examples included: o For Individuals #84 and #77, numerous SLP data sheets reflected annotations describing the lack of data collection since February 2013. o Individual #11 had no documented trials of his SAPs in May. o Individual #98 had no data for his communication program since 5/9. <u>Staff surveyed/interviewed indicate how the unified record is used</u> In the Self- Assessment, the Facility reported the interview tool had been sent to seven disciplines (Psychology, Nurse, Physician, Vocational Staff, Habilitation, QDDP, and Active Treatment Staff) each month in the months of 07/2012 to 02/2013. Of the 56 Interview Tools sent out, 51 responses had been received and five responses were still pending. Per interview of HIM staff, the URC selects one individual non-randomly, rotating across QDDP caseloads. Interview tools are sent by email. HIM staff pulled information from the returned tools, but no trending was done. Therefore, the Monitoring Team could not determine whether staff were able to identify ways in which they use information from the records. The Monitoring Team did a joint interview of two QDDPs. The QDDPs were able to provide examples in which they used information from the record (including an example about a specific individual) and how the record is used in meetings. They stated that much of the information is used to populate the ISP Guide (an agenda and information document used during the ISP annual planning meeting), so there would be less need to open the Active Record itself during the meetings. <u>Observation at meetings, including ISP meetings, indicates the unified record is used and data are reported rather than only clinical impressions</u> The Facility had a process to observe meetings and assess whether the unified record is used during meetings and data are reported. The URC observed one ISP annual planning meeting per month and documented observations on the Settlement Agreement Provision V.4—Observation for use of the Record form. This form listed nine disciplines/departments and the facility staff present from that department or discipline. For each of these, the URC documented whether the record was observed to be used, provided an example if used, whether the documents were filed in the record at the time of the meeting, what assessments were made available 14 days prior to the meeting, and whether the observation indicated that the record is used when making decisions. The Facility did not provide definitions or criteria used to rate whether records were used nor data used for analysis, but the Monitoring Team found the following through review of the monthly observation forms from November 2012 through April 2013:	

#	Provision	Assessment of Status	Compliance

Month	Disciplines Present	Record used?*	Example of how record used?*	Observation indicated record used to make decisions?*
November	4 (44%)	1 (25%)	1 (25%)	1 (25%)
December	6 (67%)	1 (25%)	1 (25%)	1 (25%)
January	7 (78%)	2 (29%)	2 (29%)	2 (29%)
February	6 (67%)	2 (33%)	2(33%)	2 (33%)
March	7 (78%)	2 (29%)	2 (29%)	2 (29%)
April	7 (78%)	2 (29%)	2 (29%)	2 (29%)

* % is percent of the staff who were present

These data from the Facility's observations did not indicate that the record was used regularly in ISP annual planning meetings. The process does have potential to provide information that can be used for coaching or for systemic improvement. The Facility should develop criteria for rating use of the record that can also be used to coach IDT members.

As noted above, the Facility's process to survey staff for use of the record did not provide trending of data; therefore, the Monitoring Team could not determine whether staff provided examples of use of the record during meetings..

At two of two (100%) ISP annual planning meetings for individuals observed by the Monitoring Team, the record was available.

At two of two (100%) ISP annual planning meetings (Individuals #118 and #134) and one pre-ISP planning meeting (Individual #48) observed by the Monitoring Team, the record was referred to for information, or information directly from the record was brought to the meeting and used. The observations indicated that information from the record was discussed and considered at times, but inconsistently.

- At the pre-ISP meeting for Individual #48, several staff looked through the Active Record for information on issues such as the current step for a SAP, assessment of swallowing, and medical issues.
- During the ISP meeting for Individual #118, data on target behaviors were reported, and the IRRF included data from the record. However, a question was asked about whether the individual had a seizure in May; although there was discussion of whether that had occurred or not, the record was not reviewed for documentation.
- During the ISP meeting for Individual #134, reference to the Active Record was

#	Provision	Assessment of Status	Compliance
		not observed. Opportunities for use of the record were missed. For example, there was no reference to an MBSS that mentioned silent aspiration, nor was the date when there was a change in diet texture due to a choking episode. Information from the FSA was not mentioned when there was a discussion of money management; during the meeting, the IDT tested his ability to count coins, rather than first see what the FSA reported.	

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, what sort of training must be completed and what specifically must be included in the training, who will provide training, and who has been trained. A centralized process should be developed at least for specific critical policies to ensure all relevant staff receive consistent training. (Provision V2)
2. The Facility needs to implement processes to ensure that items identified in records audits as needing correction are not only identified but are also corrected. (Provision V3)
3. Consider developing observation tool criteria for rating use of the record during ISP meetings that can also be used to coach IDT members. (Provision V4)

List of Acronyms

RIO GRANDE STATE CENTER

May 13-17, 2013 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
ART	Administrative Review Team
AS	Action Step(s)
AT	Assistive Technology
BAIP	Behavior Assessment and Intervention Program
BAP	Behavioral Assessment Program
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
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid Services
CEU	Continuing Education Unit
CNE	Chief Nurse Executive
COP	ICF/MR Condition of Participation
CPE	Comprehensive Psychiatric Evaluation
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/DSP	Direct Care Professional/Direct Support 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	Direct Support Professional, 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
MRP	Medication Response Profile
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
OHCP	Oral Health Care Plan
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
PMTP	Psychiatric Medication Treatment Plan
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
PSP	Personal Support Plan; Psychiatric 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
RRC	Restraint Reduction Committee
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