United States v. State of Texas

Monitoring Team Report

Rio Grande State Center
November 18-22, 2013

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Introduction

Background

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

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

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

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

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

Methodology

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

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

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

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

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

Organization of Report

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

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

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

Substantial Compliance Ratings and Progress

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

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

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

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

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

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

Executive Summary

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, especially Sandra Canales, Rosie Sanchez, Alondra Machado, Elsa Morales, Leticia Gonzalez, Angie Alejo, Mary Lou Martinez, Gary Sauceda, Andy Garcia, Belinda Portales, and Patricia Coronado. They ensured the documents requested were available before, during, and after the visit. They coordinated arrangements for all the meetings and observations. Too many other staff to mention assisted in numerous ways.

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

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

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

General Comments

Population. Population of the Facility at the beginning of the compliance visit was 65 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

In June 2013, the parties agreed that some modifications to monitoring could be made under specific circumstances. These include the following: 1) sections or subsections for which smaller samples are drawn, or for which only status updates are obtained due to limited or no progress; 2) no monitoring of certain subsections due to little to no progress for provisions that do not directly impact the health and safety of individuals; and 3) no monitoring of certain subsections due to substantial compliance findings for more than three reviews. For each review for which modified monitoring is requested, the State submits a proposal for the Monitor and DOJ's review, comment, and approval. This report reflects the results of a modified review. Where appropriate, this is indicated in the text for the specific subsections for which modified monitoring was conducted.

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

Restraints

Restraint use at the Facility occurred infrequently. Even so, there remained difficulties with documentation (although this was somewhat improved), monitoring, and lack of implementation of behavioral programs prior to use of restraint.

- Positive Practices and Improvements Made

- Use of restraint for crisis intervention and medical or dental care was minimal.
- Direct care staff knowledge of basic restraint policy had improved from that observed at the last review.
- For the third consecutive reporting period the Facility reported no use of medical restraint for dental procedures and limited use for medical procedures.

- Improvements Needed
  - Restraint review conducted by the Psychology Department identified instances where restraint was used inappropriately and without clinical justification.
  - The accuracy and completeness of restraint related documentation, including that completed by nursing staff, had improved from that observed at the last review but remained in need of further improvement.
  - In at least some cases abdominal binders are likely being used as a physical mechanical restraint for self-injurious behavior (PMR-SIB) although the Facility does not classify them as such nor follow policy requirements associated with PMR-SIB.
  - The Facility should review use of abdominal binders to ensure any used for restraint follow restraint policies.

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

In its last review the Monitoring Team found the Facility to be in compliance with 21 out of 22 provisions of Section D, the sole exception being Provision D.2.i, which addresses processes, associated with detecting under reporting of significant incidents. The Facility had improved its processes in this regard from that observed at the last review and is now in compliance with Provision D.2.i. The Monitoring Team validated continued compliance with the 21 Provisions found in compliance in the last review.

- 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 are detailed and reflect 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) continued to represent best practice.

- Self-advocate meetings were held monthly and were well attended. Abuse and neglect reporting was regularly reviewed as a means of providing ongoing education to individuals.
- The DFPS and OIG Investigator interviewed expressed a high level of cooperation between Facility administrative staff and themselves.
- 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. If an allegation made to DFPS was returned to the Facility as an administrative referral, the Facility followed up with a comprehensive thorough investigation of its own.
- 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.

<u>Quality Assurance</u>

Since the last review the Facility had updated its Quality Assurance policy and its Improving Organizational Performance Program document to include key indicators. While key indicators had been identified, and for most at least some data was being collected, this was a very new initiative requiring much refinement. At this time, the data system developed by the Facility was being used more for management oversight and performance accountability than for performance improvement purposes.

- Positive Practices and Improvements Made
  - Corrective Action Plan (CAP) initiation audits, CAP completion audits, and CAP effectiveness audits continued to be used to measure the efficacy of the QA system.
  - The Facility had initiated several administrative action steps to close the large number of its outstanding CAPs. This had proved effective in reducing the number of open CAPs with long expired due dates.
- Improvements Needed.
  - The majority of CAPs (including those designated as high priority) were not completed timely.
  - Although improved since the last compliance visit, implementation of QA processes at the Facility was variable department to department.
  - There was only limited evidence that the QA process has resulted in the identification of systemic issues requiring resolution. 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.

Integrated Protections, Services, Treatments and Supports

Although not yet in compliance with any provision of this Section, RGSC has continued to progress toward meeting the requirements. Improvements had occurred in the ISP planning processes. Improvements had occurred in completion of both routine assessments and assessments in response to significant changes in an individual's status, but continuing improvement is needed. The interdisciplinary teams still need to make significant improvements in identification of needed services and supports, development of actions and goals to address those services and supports, and identification of barriers to movement to more integrated settings.

- Positive Practices and Improvements Made
  - The QIDP was the identified facilitator for the ISP process that develops, monitors, and revises treatments, services, and supports. The QIDP led ISP meetings. Although individuals were not assisted to lead their own meetings, the QIDP and other IDT members encouraged individuals to participate in decisions.
  - Although attendance at ISP annual planning meetings was variable across disciplines, it did appear to be improving.
- Improvements Needed
  - Completion of assessments in advance of the ISP annual planning meeting and Admission ISP meeting was variable. Improvement in timeliness continues to be needed.
  - Quality and adequacy of assessments was also variable across disciplines.
  - As with timeliness and quality of assessment, the use of information from assessments varied. Information from Integrated Risk Review Forms, OT/PT assessments, and Structural and Functional Assessments were regularly used in development of skill acquisition and behavioral intervention programs. There was little evidence that information from the Functional Skills Assessment was considered in developing skill acquisition programs.
  - Assessments did not consistently include a determination of whether the individual could be served in a more integrated setting or of the protections, services, and supports the individual would need. Without that, it is difficult to identify obstacles to transition, because it is unclear which necessary supports are and are not available from providers.
  - When barriers were identified, they did not always lead to goals, objectives, or services strategies. The ISP did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his/her needs.
  - ISPs did not include a full complement of individualized goals or objectives and/or strategies to address the array of supports and services the individual required.
  - ISPs reviewed did not clearly state observable and measurable goals and objectives, nor the methods for implementation.

- Services and supports listed in the ISP were not always implemented, and staff responsible for implementation were not consistently familiar with the programs to be implemented.
- QIDPs were documenting monthly reviews, although not consistently. However, these reviews did not provide evidence of progress evaluation or program modification. Furthermore, most responsibility for reviews was assigned to the QIDP. There was little evidence that appropriate clinicians reviewed the progress of individuals on clinical services and supports.

Integrated Clinical Services

The Facility had continued to progress toward providing clinical services in an integrated manner. Although the Facility had established several processes for integration of clinical services, there was still need for improvement in the actual integration of services.

- Positive Practices and Improvements Made
  - Integrated discussion was observed at annual ISP planning meetings.
  - There were examples of collaboration across disciplines, such as psychiatry with behavioral services, and speech and language involvement with positive behavior support programs.
- Improvements Needed
  - Although the Morning Medical Report meeting had continued, this meeting needs to involve more interdisciplinary discussion; currently, it focused on reports of events and consultations. While these are useful for all disciplines to be aware of, they did not trigger identification of issues for which further discussion by this interdisciplinary group could be useful, either to provide suggestions for individual care or to identify systemic issues to address.
  - Examples of a lack of integrated care included lack of a process for psychiatry and neurology to coordinate services. In addition, IDT members were not, in some observed meetings, aware of important clinical information needed to make decisions.

Minimum Common Elements of Clinical Care

Progress toward compliance with the requirements of this Section was limited. Some improvements were noted, but other areas showed little progress. The parties agreed that Provision H2 would not be monitored at this visit.

- Improvements Needed
  - Improvement is needed in completing routine assessments on a timely basis and in response to a change in an individual's status. Quality and comprehensiveness of assessments varied across disciplines.
  - The Facility did not have procedures in place to ensure or monitor that treatments and interventions were implemented timely. Most treatments and interventions were implemented timely, but several provisions of this report provide examples in which treatments and interventions were not provided timely.

- The Facility did not provide evidence of expansion of the identification and use of clinical indicators, either for monitoring health status and assessing effectiveness of treatments and interventions for individuals or for assessing system-wide status of health care.

At-Risk Individuals

The parties agreed the Monitoring Team would not monitor this section, because the Facility had made limited progress. The noncompliance findings from the last review stand.

Psychiatric Care and Services

The Monitoring Team identified continued improvements, and movement towards substantial compliance with Provision J. The Facility had made significant enhancements in many sections, especially in areas such as assessing polypharmacy, integrating behavioral and pharmacological treatments, and by ensuring meaningful target symptoms for psychiatric conditions were identified and tracked. The Facility must continue to strive for improvements in several areas, such as improving the consent process for psychotropic medications, better collaboration with neurologists, and ensuring that Reiss Screening assessments are completed on all new admissions, within two weeks of admission to the Facility.

- Positive Practices and Improvements Made
  - The Facility had qualified professionals for the provision of psychiatric services.
  - The Monitoring Team continues to be impressed by the comprehensive review of the clinical data reviewed by the treating psychiatrist.
  - 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 Facility maintained a functional process that enables both the psychiatrist and BCBA an opportunity to review each individual who is prescribed a psychotropic medication and collaborate in developing a combined behavioral and pharmacological treatment plan.
  - Each treatment plan reviewed was individualized and assessed pharmacological, behavioral, and other nonpharmacological interventions, with a goal to utilize the least restrictive intervention.
  - The Facility assessed polypharmacy at both the system and individual level by ensuring appropriate diagnosis, targeted behaviors, and appropriateness of polypharmacy, and providing relevant recommendations to the prescribers of polypharmacy.
- Improvements Needed
  - Although there were no examples of individuals being provided pre-treatment sedation, the Facility must have a functional mechanism process to help reduce the need for pre-treatment sedation, for instances when pre-treatment sedation may be needed.

- The Facility did not provide evidence to support that an IDT, which included the psychiatrist, psychologist, nurse and primary care physician, assessed the harmful effects of psychotropic medications, alternative treatments to psychotropic medications, or if the harmful effects of the mental illness outweigh the possible harmful effects of the psychotropic medication.
- Although the prescriber signed, dated, and completed the prescriber component of the side effects assessment tools, the Facility did not perform more frequent monitoring for emerging side effects secondary to a dose increase, or addition of a new neuroleptic.

Psychological services

The Facility had continued to progress toward substantial compliance with the Settlement Agreement in relation to Section K. Although some areas continued to reflect considerable limitations, the efforts exhibited thus far by RGSC suggested that the Facility was acting in a deliberate and productive manner.

- Positive Practices and Improvements Made
  - The Facility had improved the use of behavior intervention data. PBSP progress notes were updated and reviewed monthly, with the review conducted by a BCBA.
  - PBSPs included all required elements, and reflected sophisticated examples of behavior intervention methods.
  - A second BCBA had been hired by the Facility, allowing the Facility to meet requirements for staffing ratios and demonstrably competent staff.
- Improvements Needed
  - Facility documentation did not reflect that all individuals with PBSPs were provided annual review by the Peer Review Committee.
  - PBSPs included instructions regarding data collection that permitted staff to delay recording data until the end of the shift, increasing the probability of data collection errors and potentially limiting the ability to develop sound treatment decisions.
  - Only 17% of people admitted to the Facility since the previous site visit had been provided with a Psychological Evaluation and testing within 30 days of admission.
  - The Facility did not consistently conduct assessments for data reliability or treatment integrity.

Medical Care

The Monitoring Team noted that the Facility promptly addresses acute medical conditions, documents clinical issues by dictation and in SOAP format, and provides timely screening for prostate and breast cancer. The Facility was noted to have continued issues with regards to following up on medical conditions, medical provider's participation at IDT meetings, and the annual ISPs and its mortality review process. The Facility must also develop and implement necessary policies and procedures for medical services, and enhance the medical audit process.

- Positive Practices and Improvements Made
    - The Facility continued to demonstrate prompt and efficacious management of acute medical conditions, and effective documentation practices.
- Improvements Needed
    - The Facility must enhance its ability to address chronic care issues, such as seizure disorder, osteoporosis, cerebral palsy, and fractures, among others.
    - The medical providers, and the medical component of IDT meetings and the ISP must be enhanced, and the medical provider must ensure understanding of all known medical conditions, and convey all necessary supports and services needed to manage each medical condition to the IDT members.
    - The Facility must enhance its mortality review process by ensuring that the mortality review committee has a comprehensive understanding of the underlying medical, and any related behavioral, conditions associated with the cause of death, and determine if all reasonable interventions were considered by the IDT.
    - 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; and develop a system to track clinical indicators to identify areas that require improvement.

<u>Nursing Care</u>
The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for all provisions of this Section, because the Facility had made limited progress. The noncompliance findings from the last review stand.

The areas that had made the most progress were recently formalized processes for making nursing referrals to present at the Morning Medical Report meetings and improvements made in the 24 Hour Nursing Log. Several internal nursing monitoring tools were streamlined into more meaningful and useful tools for management. Improvements were made in medication management processes. The areas of least improvement were found in the timeliness and quality of the nursing assessments and in development and implementation of individualized acute care plans.

- Positive Practices and Improvements Made
    - The Nursing Department was fully staffed with a Chief Nurse Executive, Nursing Operations Officer, Unit Nurse Manager, and Nurse Educator. The Facility had made several improvements in the day to day management of the nursing operation.
    - The Facility continued to conduct and to expand the integrated participation of staff attending Morning Medical Report meetings.

    - A full time Nurse Educator was hired since the last compliance review. In the short time since she had been hired she had begun to make significant improvements in the development and implementation of centralized systems for tracking all nursing training.
    - The Facility had restructured the medication administration areas in on unit and was in process of doing this for the second. Where this had already been done, it improved the efficiency and accuracy of the exchange, enhanced the ability to reconcile medications, and reduced distractions.
- Improvements Needed
    - There was a continuing deficit in assessing and documenting acute illness and injuries, particularly infections.
    - Annual/Quarterly Nursing Assessment showed no appreciable improvement in timeliness, content, and quality. It is essential that nursing administration urgently make improvements in this area of performance in order to move forward toward compliance with this Provision.
    - IRRF and IHCP processes were evolving. As more training is provided and experienced is gained by the IDTs and the respective disciplines in developing and implementing these processes, continued improvements should be made in the content of the clinical data and quality of these processes. There continued to be variation in the content and quality of IRRFs and IHCPs completed by different IDTs.
    - The Facility needs to ensure that all individuals' IHCPs that require Direct Care Professional Instruction Sheets are completed and placed in their "Me Book" for ready access by the direct care professional.
    - The Acute Care Plans need to be more individualized and to incorporate relevant nursing protocols.
    - All care plans should show documentation that they were carried out according to the plans and followed through to resolution.
    - All medication variances committed by the responsible disciplines must be reported and corrective action provided when necessary.

<u>Pharmacy Services and Safe Medication Practices</u>
The Facility significantly improved assessment of new medications. Other than Section N1, each section demonstrated significant deficits.

- Positive Practices and Improvements Made
    - All new medication orders reviewed demonstrated that the pharmacists documented review for clinical appropriateness, allergies, interactions, appropriate dose and necessary clinical diagnostics.
- Improvements Needed
    - The Facility must continue to enhance its QDRR process by ensuring that QDRRs are completed at least quarterly; document the appropriateness of all medications prescribed; and ensure that the psychiatrist reviews, signs, and acts upon QDRRs that include the use of medications for psychiatric indications.

- There was significant delay in completing QDRRs within the quarterly time frame. The Facility must immediately address this delay.
- The Facility must also enhance the QDRR process with regard to its review of polypharmacy, benzodiazepine, and anticholinergic drug usage, and review of metabolic syndrome. The Facility performs excellent systems, and individual, review of polypharmacy, but systems review of metabolic syndrome, and of benzodiazepine and anticholinergic drug usage, must be improved.
- The psychiatrist did not indicate review of the QDRRs, and did not indicate either agreement or disagreement with the pharmacist's recommendation.
- The Facility did not perform more frequent monitoring for emerging side effects secondary to a dose increase, or addition of a new neuroleptic.
- The Facility did not have a policy and procedure for its adverse drug reaction (ADR) process and did not have an effective mechanism to track and trend ADRs.
- Improvements are needed in the drug utilization evaluation process.
- The Facility must track medication variances caused by all disciplines, including medical providers.

<u>Physical and Nutritional Management</u>
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.

- Positive Practices and Improvements Made
  - The Physical and Nutritional Management Team (PNMT) met regularly, which was positive, and evidence had shown improvement in 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.
  - PNMPs were much improved and were felt to contain the areas needed to address PNM issues.
- Improvements Needed
  - The monitoring system, while more formal, remained unclear regarding the criteria in which individuals received certain levels of monitoring.
  - An overriding concern noted appeared to be a lack of implementation of plans of care.
  - 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 a lack of integration of the PNMT recommendations into the ISP and IHCP that included established thresholds for referral back to the PNMT.
  - Timeliness of updating PNMPs needs to improve.

- 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.
- Assessment for return to oral eating was highly dependent on their completion of a MBSS and was specific to whether the person could currently tolerate versus providing treatment to increase potential to tolerate.

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, especially on El Paisano.

A system still did not exist and 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 did not clearly identify how areas in which skill acquisition or generalization of skills were needed were not consistently included as part of the assessment.
  - 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.
  - Progress notes were not comprehensive and did not provide a clear pathway to treatment expectations.
  - The Facility was unable to provide information regarding if staff had been trained on individuals' plans of care. 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.

Dental Services

The Monitoring Team recognized that the Facility maintains clinically adequate community resources to provide dental services, and ensures that individuals are provided timely restorative dental care, and regular dental imaging. The Facility must, however, continue to improve dental services by enhancing its programs for oral hygiene at the living area, the use of suction toothbrushing, monitoring individuals following dental anesthesia, developing a dental scheduling system that enables efficient and effective review of dental services provided to each individuals, and implementing a dental QA program that assesses the efficacy of dental services and potential adverse outcome following dental services.

- Positive Practices and Improvements Made

- The Facility demonstrated effective follow-up on restorative dental needs and dental radiography.
- For the most part, annual dental appointments were completed, and new appointments had been established to complete those that were delayed.

- Improvements Needed
  - The Facility needs to enhance its procedure for managing dental emergencies, and ensure that dental emergencies are triaged promptly.
  - The Facility did not have functional processes in place to address the Facility's oral hygiene and suction toothbrushing programs.
  - The Facility should develop a program that helps individuals become accustomed to the dental milieu, and associated oral treatments; and should ensure that the program is offered at a frequency that will help the individual overcome challenges related to the dental office experience. The Facility must track and trend the effectiveness of the program for each individual.
  - The Facility must develop a clinically effective mechanism to ensure close monitoring of all individuals following TIVA and other forms of anesthesia, including pre-treatment oral sedation.
  - It is essential that the Facility develop a dental QA process that assesses the quality and efficacy of dental services, including regularly assessing potential adverse outcomes, such as pneumonia, behavioral exacerbation, and injuries, such as fractures, following dental procedures.

<u>Communication</u>

RGSC requested reduced monitoring for Sections R.2, R.3., and R.4. As part of this request, RGSC chose the individuals to be included as part of the sample. The chosen individuals were those that had received newer assessments, treatment plans, etc. Since the review was limited in sample and scope, substantial compliance could not be rated by the Monitoring Team for Sections R.2 through R.4. Provision R.1 was found to be in substantial compliance.

- Positive Practices and Improvements Made
  - The speech staff was fully staffed and had had the time needed to develop more guidelines and process that would assist them in being able to manage their caseload as well as other possibilities. The increase in communication skill programs was felt to be reflective of their increased ability to perform the tasks needed.
  - RGSC did have a comprehensive communication procedure/policy that addressed all components of a functioning system.
- Improvements Needed
  - 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.
  - AAC devices were not consistently utilized by individuals.
  - Direct support professionals interviewed were not consistently knowledgeable of the communication programs.

- There was limited monitoring of communication devices or integration of communication programs and strategies into the IDT.

Habilitation, Training, Education, and Skill Acquisition Programs

It was not apparent that the Facility had ensured that individuals were provided with adequate assessment or training. Although improvements were noted in some areas, efforts toward compliance were often fragmented. If the Facility wants to ensure further progress, it will be important that efforts are closely coordinated and that qualitative measures are developed and implemented

The Facility did demonstrate progress in some discrete areas.

- Positive Practices and Improvements Made
  - The components of skill acquisition programs, such as consequences, discriminative stimuli, and opportunities for the target skill, had improved.
  - Functional engagement had continued to improve in relation to percentage of individuals engaged and the locations with greater than 50% engagement.
  - The Facility had substantially increased opportunities for skill acquisition training in the community.
- Improvements Needed
  - Skill acquisition programs were seldom based upon adequate assessment or information presented in the ISP.
  - Skill acquisition training programs often lacked a task analysis where appropriate, and did not provide an adequate number of training trials.
  - It was often unclear that assessment reports were completed at least annually.

Most Integrated Setting

RGSC continued to make progress toward planning for transition. It was less clear that progress was being made toward identification of obstacles to transition and addressing them, toward identifying the supports individuals would need, and toward timely completion of comprehensive assessments.

The last compliance report stated that the Facility continued to make progress in encouraging and assisting individuals to move to more integrated settings and had continued to refer individuals for such movement. Since the last compliance visit, there have been both signs of continuing progress and signs that such encouragement and assistance has not maintained at the same level.

- Positive Practices and Improvements Made
  - The process of developing Community Living Discharge Plans continued to improve, and evidence was provided of IDT involvement as the CLDP plan evolved during the transition process.

- The Facility coordinated with potential providers during the transition process. Coordination included trial visits and assessment of those to help select a provider and training of provider staff prior to trial and pre-transition visits.
- CLDPs clearly identified who from the Facility and provider was responsible for each support.
- Post move monitoring was timely and thorough.

- Improvements Needed
  - The Facility needs to ensure that the annual assessments by professionals clearly state their independent determinations of the appropriateness of movement to a more integrated setting, as well as description of the supports that an individual would need.
  - The IDT still failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, particularly since the teams often failed to appropriately identify the most integrated setting.
  - The Facility had taken actions to educate individuals and families/LARs, including providing individuals with opportunities to tour community settings and inviting families and LARs on tours to community providers along with their family members. The Facility must improve provision of individualized plans for education and should provide opportunities to learn about success stories.
  - The IDT needs to identify more comprehensively the obstacles to movement. For those obstacles that are identified, the IDT needs to develop individualized plans to overcome them.
  - CLDPs did not consistently identify clearly the timelines for implementation of supports. The documents provided did not consistently provide evidence that supports to be available on the day of move had been found to be in place by either the Local Authority or the Facility.

<u>Consent</u>

The parties agreed the Monitoring Team would not monitor Provision U1 because the Facility had made limited to no progress due to the lack of capacity assessment. The noncompliance finding from the last review stands.

Nonetheless, the Monitoring Team would like to note that the Human Rights Officer has been working with other Facility staff to develop and implement more careful assessment of capacity of individuals to participate in making choices, and has developed a process to identify individuals who may benefit from an advocate in the absence of, or as an alternative to, guardianship.

The Facility continued to work diligently to find guardians for individuals at high priority of need and to obtain advocates for individuals for whom advocacy is determined to be more appropriate.

- Positive Practices and Improvements Made

- The Facility had established a distinct Guardianship Committee for the ICF-IID program. This committee was new; training of committee members had begun.
- The Human Rights Officer has been working with other Facility staff to develop and implement more careful assessment of capacity of individuals to participate in making choices, and has developed a process to identify individuals who may benefit from an advocate in the absence of, or as an alternative to, guardianship. One new advocacy had been established.
- RGSC had continued the remarkable participation of individuals in the self-advocacy meetings. Not only did the self-advocacy group maintain attendance by a very high percentage of the individuals who reside at the Facility (with reports to SA-PIC documenting attendance of 40% to 62% of individuals), but also it was clear that individuals had experienced participation frequently. The Facility reported continuation of the collaboration for self-advocacy training with the Arc of Texas and Educare. Although not specifically related to obtaining guardians, these opportunities may assist individuals to gain skills at making decisions about their lives so that they can benefit from relationships with advocates.

- Improvements Needed
  - Several guardianships had been renewed, but no new guardians had been obtained. Despite diligent work, the Facility must be more effective at establishment of guardianship. The Monitoring Team understands the difficulty of this and the need for assistance with barriers such as reducing the cost to become a guardian.

<u>Recordkeeping and General Plan Implementation</u>

The Facility continues to approach substantial compliance with the requirements of this provision. The Facility continues to maintain a Unified Record that includes all required components and in which documents can usually be found. The Unified Record contained all required components. Because all filing is done by the Health Information Management department, there might be an expectation that all documents would be available in the record. This, however, would require that all documents be provided timely. The Facility had a rigorous audit process, but that had not resulted in availability of documents or improvements in compliance with Appendix D requirements. The Facility made extensive use of an electronic record system, the Clinical Work Station (CWS). That made documents accessible but was cumbersome to use. The Facility also made use of a share drive that was not considered part of the unified record but allowed information to be easily accessible to members of the IDT.

- Positive Practices and Improvements Made
  - The Facility maintained a Unified Record for each individual that included all required components.
  - The Facility provided training during New Employee Orientation (NEO) to staff who document in the Unified Record. New Employee Orientation (NEO) training materials were revised in July 2013, including creating a competency test of knowledge; the Monitoring Team suggests the test be revised so it also includes testing of documentation.

- Active Records and Individual Notebooks were both secure and accessible to staff.
- Presence of required documents in the record remained high, and compliance with Appendix D requirements was stable but continued to need improvement.
- The Facility had made progress in improving the process for notifying and training staff on new and revised policies and had developed policies and procedures that are needed to guide compliance with requirements of the Settlement Agreement.
- The Facility had implemented procedures to determine the training needed for new and revised policies, to require competency tests when appropriate, and to track training.
- The Facility continued to have 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
  - Records on the CWS were accessible to designated staff but the process continued to be cumbersome.
  - Both DADS and RGSC had continued to develop new policies and processes, a positive finding, but the Monitoring Team, in its review, discovered several that the Facility had not reported. The Facility should ensure it has an ongoing and accurate list of current policies.
  - Two areas of improvement in the audit process noted in the last report continue to be 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 records were accessible, information from them was not consistently used in decision-making or in provision of services. Use of data and other information at ISP planning meetings was variable, with some reporting of objective data, some reporting of impressions, and some lack of knowledge of data that were available in the Active Record.

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 11/6/13 2. RGSC Action Plan 11/5/13 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 (10/13) 8. RGSC SOP ICF-IID 400-16 Premedication for Medical and Dental Procedures (10/13) 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 5/13 through 9/13 12. Medical Restraint Log 5/13 through 9/13 13. Restraint Trend Report 10/31/13 14. Settlement Agreement Program Improvement Council (SA-PIC) minutes (5/13 through 10/13) 15. Training records for restraint monitors relative to Sample C.1 16. 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 three restraints that occurred since the last review (Individuals #2, #93, and #140). 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 24 staff. 19. Sample C.3 Medical Restraints - this was a 100% sample that included all six restraints that occurred since the last review. These restraints were all of Individual #15. 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. Restraint records for chemical restraint of Individual #93 (11/8/13 restraint) 21. Records related to Individuals #79, #19, and #126 (abdominal binders) **People Interviewed:** 1. Rueben Nieto, BCBA, Psychology Manager 2. Berenice Martinez, BCBA

	3. Mary Ramos, QA Director 4. Benjamin Perez, Jr., Director of Competency Training and Development 5. Twelve Direct Support Professionals **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 11/20/13 2. Settlement Agreement Performance Improvement Council (SA-PIC) 11/21/13
	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 and used a data recording tool developed specifically for this purpose.. ▪ The Facility presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings based on specific, measurable indicators. o 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 12/31/13. ▪ 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. The Monitoring Team did not identify any significant issues that the self-assessment process did not already discover and report.
	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 instances where restraint was used inappropriately and without clinical justification. The accuracy and completeness of restraint related documentation, including that completed by nursing staff, had improved from that observed at the last review. In at least some cases abdominal binders are likely being used as a physical mechanical restraint for self-injurious behavior (PMR-SIB) although the Facility does not classify them as such nor follow policy requirements associated with PMR-SIB. Direct care staff knowledge of basic restraint policy had improved from that observed at the last review. For the third 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 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.	In its last report the Monitoring Team noted that the Facility had two separate and distinct policies governing the use of restraint. These were 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 were not 100% congruent. For example, NR400-20 did not include the requirements associated with protective mechanical restraint for self-injurious behavior (PMR-SIB) required in State policy. The Monitoring Team suggested that the Facility should review each policy and make certain 1) all requirements of State policy are included, and 2) procedural requirements dictated in each policy are consistent within one another. This review had not occurred. Some of the problems associated with nursing follow-up reported in Provision C.5 could be attributable to inconsistent policy direction. Additionally, the Facility had 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 Monitoring Team suggested in its last report that 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. It was reported that no Facility assessment of this suggestion had occurred. Data provided by the Facility for the past two six month periods, showed:	Noncompliance

#	Provision	Assessment of Status	Compliance

Type of Restraint	10/1/12 to 3/31/13	4/1/13 to 10/31/13
Crisis Intervention (physical holds)	7	6
Crisis Intervention (chemical restraint)	3	0
Crisis Intervention (mechanical restraint)	0	0
TOTAL Crisis Intervention Restraints	10	6
TOTAL Individuals represented in above total	7	4
Of the above individuals, those restrained pursuant to a Crisis Intervention Plan	0	0
Medical restraints/dental Medical restraints/medical procedures	4 0	0 8
TOTAL individuals restrained for medical/dental reasons	2	4

Subsequent to the preparation of Sample C.1 the Monitoring Team was informed of a recent restraint of Individual #93 that concluded with use of chemical restraint. It should also be noted that the Self-Assessment for Provision N3 stated, "when an emergency chemical restraint for behaviors was needed, reviews for the events were conducted to ensure clinical appropriateness". In this case, the Monitoring Team was informed that there were no chemical restraints administered during the time frame that was assessed. The self assessment for Section N.3 also indicated that "There were seven Chemical restraints from 04/2013 through 09/2013. Audit data supports the events were appropriately addressed and documented." This brings into question the data provided.

The Facility is to be commended for its continued decrease in both the number of Individuals subjected to crisis intervention restraint and the frequency in which restraint is required for these Individuals.

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

#	Provision	Assessment of Status	Compliance
		Based on review of other documentation (trend reports and lists of restraints) use of prone restraint was not identified. A sample, referred to as Sample C.1, was selected (a list is provided in the Documents Reviewed Section above). Based on a review of the restraint records for individuals in Sample C.1 involving three individuals, none (0%) showed use of prone restraint. Based on questions posed to 12 direct support professionals, all 12 (100%) were aware of the prohibition on prone restraint. This was a significant improvement from that noted in the last review (42%). The Facility has a process for checking staff competencies. Each month 10 staff, randomly selected, were quizzed by the Human Rights Officer (HRO). The HRO provided on the spot retraining if needed. Data collected on these competency checks was maintained and a monthly summary prepared and presented to the QA Director and the SA-PIC. <u>Other Restraint Requirements</u> 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; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. The Facility reported it did not use Physical Mechanical Restraint for Self-Injurious Behavior (PMR-SIB); however, in reviewing the records associated with the use of abdominal binders for three Individuals (Individuals #79, #19, and #126) it appears that in at least two cases (67%) the primary purpose of the binder was related to the Individual's voluntary behavior. In these instances the use of the abdominal binder is a PMR-SIB and all policy requirements associated with use of such restraints must be followed. The Facility needs to review each of these three cases against restraint policy definitions and ensure proper classification as a restraint when appropriate. Subsequent to this review the Facility must ensure all relevant policy requirements, including documentation, are met. 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 three of the three records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others.	

#	Provision	Assessment of Status	Compliance
		• For the three restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that one (33%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. This was not the case with restraint of Individuals #2 and #140. In both cases the post restraint review conducted by the psychology department determined that the Individual's Behavior Support Plan was not followed and as a result restraint may have been avoided. • In one of the records (33%), 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. This was not the case with restraint of Individuals #2 and #140. In both cases the post restraint review conducted by the psychology department determined that the Individual's Behavior Support Plan was not followed and as a result restraint may have been avoided. • Facility policies do identify a list of approved restraints. • Based on the review of three restraints, involving three individuals, three (100%) were approved restraints. • In one of these records (33%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. This was not the case with restraint of Individuals #2 and #140. In both cases the post restraint review conducted by the psychology department determined that the Individual's Behavior Support Plan was not followed and as a result restraint may have been avoided. Based on this review this Provision was not in substantial compliance.	
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 three 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 three individuals who did not have Crisis Intervention Plans, one (33%) included sufficient documentation on the Restraint Checklist to show that the individual was released as soon as the individual was no longer a danger to him/herself. This was not the case for Individuals #93 and #149. In both cases code Y (release completed) was reported on the Restraint Checklist. In neither case was any other code used that would indicate the individual was no longer a danger to him/herself. For all three restraints the Face-to-face Assessment Debriefing form noted that the Individual was released from restraint as soon as the Individual was no longer a danger to him/herself or others. The Restraint Checklist is a primary source of restraint documentation. Data reported on the Restraint Checklist is expected to be correct and other restraint related documentation is	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		expected to be consistent with data recorded on the Restraint Checklist. Any inconsistencies noted in post restraint review should be reconciled. The Facility had achieved substantial compliance with this Provision for the last two reviews. Based on this review this Provision remains in compliance because temporary failure to comply during a period of otherwise sustained compliance, does not constitute failure to maintain substantial compliance. The issues noted above must be corrected in order to maintain continued compliance.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The Facility's policies related to restraint are discussed above with regard to Section C.1 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: 1. Policies governing the use of restraint; 2. Approved verbal and redirection techniques; 3. Approved restraint techniques; and 4. Adequate supervision of any individual in restraint. Sample C.2 was selected from a current list of staff. A description of Sample C.2 is provided in the Documents Reviewed section above. A sample of 24 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: • All 24 (100%) had current training in RES0105 Restraint Prevention and Rules. • Twenty-three of the 24 (96%) had completed PMAB training within the past 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. Each response was evaluated by one member of the Monitoring Team, the Facility's Quality Assurance Director, and the Facility's QA Program Analyst. Consequently, for each question, responses were subjected to 36 evaluations (twelve Individuals times three raters). Based on responses to questions, 12 direct support professionals provided satisfactory responses to the following questions as follows: 1. "Policies governing the use of restraint require that restraint should only be used if the Individual poses an ____and only after_____." Thirty of 36 responses were	Noncompliance

#	Provision	Assessment of Status	Compliance
		evaluated as satisfactory (83%). This compares to the compliance percentage of 22% reported in the last review. 2. "Describe an example of a redirection technique." Thirty-five of 36 responses were evaluated as satisfactory (97%) This compares to the compliance percentage of 72% reported in the last review. 3. "Describe two physical restraint techniques approved for use at the Facility." Thirty-six of 36 responses were evaluated as satisfactory (100%). This compares to the compliance percentage of 75% reported in the last review. 4. "What level of supervision is usually required when an Individual is in restraint?" Twenty-seven of 36 responses were evaluated as satisfactory (75%). This compares to the compliance percentage of 39% reported in the last review. 5. "Under what circumstances is it OK to use prone restraint?" Thirty-six of 36 responses were evaluated as satisfactory (100%). This compares to the compliance percentage of 42% reported in the last review. The Facility had a process for checking staff competencies. Each month 10 staff, randomly selected, are quizzed by the Human Rights Officer (HRO). The HRO provided on the spot retraining if needed. Data collected on these competency checks was maintained and a monthly summary prepared and presented to the QA Director and the SA-PIC. As reported in Provision C.1 for Sample C.1 for only one of the three restraints (33%), 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. Policies were written. Staff were, for the most part, knowledgeable but could not consistently describe types of approved physical restraints or the level of supervision required (although this had improved). Regardless of the requirements being written in policy and staff being generally knowledgeable, the policies were not fully and accurately implemented. Based on this review this Provision was not in compliance.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine	Based on a review of three restraint records (Sample C.1), in three (100%) there was evidence that documented that restraint was used as a crisis intervention. In review of two Positive Behavior Support Plans, in two (100%), there was no evidence that restraint was being 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	The Facility reported it used a "Medical Considerations" form to document that no restraint is used that is prohibited by the individual's medical orders, or, if there are medical considerations they are described and recorded on this form. This form is completed and signed and dated by the physician. This form was present in two of three (67%) cases. This was not the case with Individual #140. This same form is used to document interdisciplinary team (IDT) considerations associated with restraint. One of two choices is to be checked on the form: 1) "modification of restraint (see staffing summary or behavior program)", or 2) "no modification of restraint". In the two cases where this form was present no entries were made to either of the above even though the QIDP signed and dated the form. Therefore these data were missing in three of three (100%) of Sample C.1. Medical restraint was used with only one Individual (#15). This individual had medical restraint six times in this review period. In reviewing documentation prepared by the Facility the Monitoring Team determined that: • These restraints did not have appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent). • There was no documentation that the Facility attempted to develop treatments or strategies to minimize or eliminate the need for restraint. Based on this review this Provision was not in substantial compliance.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a	In its last review the Monitoring Team reported that there was not an adequate training curriculum on the application and assessment of restraint because the Facility was unable to describe or provide documentation that was Facility specific with regard to Restraint Monitor training. The Facility reported this was still the case. 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, the three staff at the Facility who performed the duties of a restraint monitor for Sample C.1 three (100%) successfully completed the	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	above training which according to policy allows them to conduct face-to-face assessment of individuals in crisis intervention restraint. Based on a review of three restraint records (Sample C.1), a face-to-face assessment was conducted: • In all three incidents of restraint (100%) by an adequately trained staff member. • In all three instances (100%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. • In all three (100%), the documentation showed that an assessment was completed of the application of the restraint. • In all three (100%), the documentation showed that an assessment was completed of the consequences of the restraint. There were no instances where a physician ordered an alternative monitoring schedule for restraint of any of the three Individuals in Sample C.1. Based on a review of three 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 15 minutes from the initiation of the restraint in three (100%) of the instance of restraint. • Monitored and documented vital signs in one (33%). Records that did not contain documentation of this included Individuals #2 and #93. • Monitored and documented mental status in one (33%). Records that did not contain documentation of this included Individuals #2 and #93. In its last report the Monitoring Team noted that the nursing staff needed retraining on the Crisis Intervention Restraint Policy and Restraint Checklist. Retraining did occur but based on the above data more is needed. None of the three restraints in Sample C.1 occurred off campus. Sample C.3 included the one Individual who had medical restraint in the last six months. For this Individual, who had six medical restraints, the Monitoring Team determined through review of documentation that: • In none (0%), did the physician specify the schedule of monitoring required or specify that a facility policy/protocol regarding this was to be followed. • In none (0%), did the physician specify the type of monitoring required if it was different than the facility policy/protocol. Consequently, In none of the medical restraints (0%), was appropriate monitoring	

#	Provision	Assessment of Status	Compliance
		completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. Based on this review this Provision was not in substantial compliance.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample (Sample C.1) of three Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: 1. In three (100%), continuous one-to-one supervision was provided; 2. In three (100%), the date and time restraint was begun; 3. In three (100%), the location of the restraint; 4. In one (33%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. This was not the case with Individuals #93 and #140; 5. In three (100%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8; 6. In three (100%), the specific reasons for the use of the restraint; 7. In three (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; 8. In three (100%), the names of staff involved in the restraint episode; 9. In three (100%), the level of supervision provided during the restraint episode; 10. 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. 11. In three (100%), the date and time the individual was released from restraint; and 12. In three (100%), 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 three records (Sample C.1), restraint debriefing forms that contained data consistent with that reported on the Restraint Checklist had been completed for two (67%). This was not the case for Individual #2. Injury related entries on the Restraint Checklist and the FFAD were not consistent. For the one Individual subject to medical restraint (6x) there was no evidence that the monitoring had been completed as required by the physician's order because the physician order did not specify the schedule and type of monitoring required. Sample C.1 did not include any Individual who had had chemical restraint (for crisis	Noncompliance

#	Provision	Assessment of Status	Compliance
		intervention) since the last on-site review; however, subsequent to the preparation of Sample C.1 the Monitoring Team was informed of a recent restraint of Individual #93 that concluded with use of chemical restraint. The Monitoring Team reviewed documentation associated with this chemical restraint. There was no documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, to assess whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. This was a continuing pattern at the Facility as the Monitoring Team noted in its last report that in none of the three chemical restraints reviewed was this requirement met. Additionally, documentation of nursing monitoring subsequent to the administration of the chemical restraint reported only one assessment 30 minutes after administration of the chemical restraint, not every 15 minutes for two hours as required by policy and the Facility did not produce the post restraint review by the psychiatrist and pharmacist required no later than 10 days after the use of chemical restraint for crisis intervention. Based on this review this Provision was not in substantial 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, there were no Individuals placed in restraint more than three times in any rolling thirty-day period since the last review. 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		Not rated

#	Provision	Assessment of Status	Compliance
	objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;		
	(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.	A sample of documentation related to three incidents of non-medical restraint was reviewed (Sample C.1), including the Restraint Checklists, Face-to-face Assessment Debriefing forms, ISPAs, IMRT minutes, Corrective action Plans, RGSC restraint monitoring tools, morning medical meeting minutes, and restraint debriefing documents that included review of video surveillance tapes and staff interviews. This documentation showed that: • In three (100%), the review by the Unit IDT (the Facility reported that the RGSC morning medical meeting serves the function of a unit meeting) occurred within three business days of the restraint episode and this review is documented by signature on the Restraint Checklist.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• In three (100%), the review by the IMRT occurred within three business days of the restraint episode and this review is documented by signature on the Restraint Checklist. • In three (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 in scope and depth 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. Minutes of the morning medical meeting did not reflect any discussion or review of the restraint episode and appeared to only record that the event happened. This was also the case with the IMRT minutes for restraint of Individuals #2 and #93. The IMRT minutes for restraint of Individual #140 included an adequate description of the events leading up to the restraint and the efficacy of the restraint episode. Additionally, the restraint monitoring tool for all three restraints did not identify the deficient nurse monitoring reported in Provision C.5. • In three (100%), referrals were made to the IDT, as appropriate; and • In each case appropriate changes were made to the individuals' ISPs and/or PBSPs. Based on this review this Provision was not in substantial compliance.	

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 11/6/13 2. RGSC Action Plan 11/5/13 3. RGSC Section D Presentation Book 4. DADS Policy 2.1 Protection From Harm - Abuse, Neglect, and Exploitation 5/11/11 5. DADS Policy 2.2 Incident Management 11/20/12 6. DADS State Supported Living Center Procedure: Injury Audits (undated) 7. RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation (11/13) 8. RGSC SOP ICF-IID 200-03 Incident Management (11/13) 9. RGSC SOP ICF-IID 400-01 Injuries to Consumers (7/12) 10. RGSC Unusual Incident Investigation Review Checklist (3/31/13) 11. Witnessed Injury Log 5/18/13 to 11/18/13 12. Discovered Injury Log 5/18/13 to 11/18/13 13. Unusual Incident and serious injury logs 5/18/13 to 9/30/13 14. DFPS Investigation case Log 5/18/13 to 9/30/13 15. OIG Investigation case Log 5/18/13 to 9/30/13 16. Material used to educate guardians on abuse reporting (2/12) 17. Sample documentation of employee discipline taken post investigation 18. Incident Management Review Team (IMRT) minutes for meetings on 7/22, 7/29, 8/5, 8/12, 8/19, 8/26, 9/3, 9/9, 9/16, 9/23, and 9/30/13 19. Self-Advocates meeting minutes 6/26, 7/31, and 8/28/13 20. Meeting minutes: DFPS/OIG/RGSC Quarterly Coordination meeting held 9/11/13 21. Injury Audit Record Reviews for June, July, August, and September, 2013 22. Sample D.1: included a sample of eight DFPS investigations of abuse, neglect, and/or exploitation (with the companion Facility investigation reports) that were selected from the log of DFPS cases since the last review. The sample represented eight of the 16 investigations (a 50% sample) reported on the log. These eight investigations included allegations of abuse, neglect, and administrative referrals and resulted in confirmed, unconfirmed, and inconclusive findings. Investigation records included: cases 42875731, 42862087, 42836077, 42831340, 42827062, 42807740, 42790933, and 42784255. 23. Sample D.2: included a sample of five investigation reports completed only by the Facility that was selected from the log of serious injuries and incidents since the last review. The sample represented five of nine (56%) reported facility only investigations. Investigation records included UIRs 14-002, 13-033, 13-031, 13-028, and 14-001. 24. Sample D.3 included 14 Individual Support Plans (ISPs) for Individuals #85, #60, #4, #46, #149, #45, #2, #35, #131, #31, #140, #19, #79, and #126. 25. DFPS case 42920805 **People Interviewed:**

	1. Myrna Wolfe, Incident Management Coordinator (IMC) 2. Sonia Hernandez-Keeble, Facility Director 3. Blas Ortiz, Assistant Director 4. Claudia Lucio, Facility Investigator 5. Rosa Sanchez, QA Coordinator 6. Mary Ramos, Quality Management Director 7. Sandra Canales, QA Program Analyst 8. Vanessa Alvarez, Human Rights Officer 9. Michael Rodriguez, DFPS Investigator 10. George Elizondo, OIG Investigator 11. George Romero, QDDP Coordinator 12. Twelve Direct Support Professionals **Meetings Attended:** 1. Incident Management Review Team (IMRT) 11/20/13 2. Settlement Agreement Performance Improvement Council (SA-PIC) 11/21/13
	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 all 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 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, and CAP Effectiveness Audits. 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 Some degree of 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 all 22 Provisions. 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: In its last review the Monitoring Team found the Facility to be in compliance with 21 out of 22 provisions of Section D, the sole exception being Provision D.2.i which addresses processes associated with detecting under reporting of significant incidents. The Facility had improved its processes in this regard from that observed at the last review and is now in compliance with Provision D.2.1. The Monitoring Team validated continued compliance with the 21 Provisions found in compliance in the last review. The Facility is to be commended for its steady improvement in reaching compliance with Section D requirements. In the past four reviews the number of compliant Provisions has gone from 11 to 15 to 21 to 22. 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 are detailed and reflect 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) continued to represent best practice. Self-advocate meetings were held monthly and were well attended. Abuse and neglect reporting was regularly reviewed as a means of providing ongoing education to individuals. The DFPS and OIG 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. If an allegation made to DFPS was returned to the Facility as an administrative referral, the Facility followed up with a comprehensive thorough investigation of its own. 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.

#	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 parties agreed the Monitoring Team would conduct a limited review of this Provision because previous reviews showed substantial compliance. The Monitoring Team reviewed sufficient documentation to ascertain continued compliance. 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 illustrated by examples provided throughout this Section D of the report. Based on this review the Monitoring Team determined this Provision remained in compliance.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such	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	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>the requirements of the Settlement Agreement.

Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and to review carefully whether for incidents that were preventable, adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed and appropriate actions taken. The Facility's progress in analyzing data collected, and addressing issues identified is discussed in further detail with regard to Section D.4 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>11/1/11 to 10/31/12 (previous 12 months)</th><th>11/1/12 to 10/31/13 (recent 12 months)</th></tr>
<tr><td>Total physical abuse allegations</td><td>40</td><td>24</td></tr>
<tr><td>Number confirmed</td><td>4</td><td>0</td></tr>
<tr><td>Number inconclusive</td><td>3</td><td>3</td></tr>
<tr><td>Total verbal/emotional abuse allegations</td><td>4</td><td>8</td></tr>
<tr><td>Number confirmed</td><td>1</td><td>1</td></tr>
<tr><td>Number inconclusive</td><td>0</td><td>1</td></tr>
<tr><td>Total neglect allegations</td><td>19</td><td>15</td></tr>
<tr><td>Number confirmed</td><td>1</td><td>2</td></tr>
<tr><td>Number inconclusive</td><td>1</td><td>0</td></tr>
<tr><td>Total exploitation allegations</td><td>2</td><td>0</td></tr>
<tr><td>Number confirmed</td><td>0</td><td>0</td></tr>
<tr><td>Number inconclusive</td><td>0</td><td>0</td></tr>
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#	Provision	Assessment of Status	Compliance
		Other Serious Incidents	

	11/1/11 to 10/31/12	11/1/12 to 10/31/13
Deaths	1	1
Serious Injuries	9	16
Sexual Incidents	2	2
Suicide Threat (credible)	0	1
Unauthorized Departure	4	3
Choking	2	2
Other	0	0

Based on the Monitoring Teams' review of DADS revised policies, including Policy 021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy 002.4 on Incident Management, dated 11/10/12: Section V.A: Notification to Director, the policies were consistent with the Settlement Agreement requirements.

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.

In order to assess 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. Each response was evaluated by one member of the Monitoring Team, the Facility's QA Director, and the Facility's QA Program Analyst. Consequently, for each question 36 responses were evaluated (twelve Individuals' times three raters). Based on responses to questions, 12 direct support professionals provided satisfactory responses to the following questions as follows:

#	Provision	Assessment of Status	Compliance
		"What is the reporting procedure and timeframe when abuse/neglect is suspected?" 18 of 36 responses were evaluated as satisfactory (50%). This compares to the compliance rate of 69% reported in the last review. "What is the reporting procedure and timeframe for other serious incidents?" 12 of 36 responses were evaluated as satisfactory (33%). This compares to the compliance rate of 67% reported in the last review. The above data suggests staff is not retaining information learned in formal training classes. The Facility had a process for checking staff competencies. Each month 10 staff, randomly selected, was quizzed by the Human Rights Office (HRO). If on the spot retraining was needed the HRO provided it. Data collected to these competency checks is maintained and a monthly summary is prepared and presented to the QA Director and the SA-PIC. The Facility may need to engage in additional strategies to reinforce key provisions of abuse and serious incident reporting policy. Based on a review of the eight investigation reports included in Sample D.1: • Eight (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by DADS/Facility policy. Investigation 42831340 presented an unusual situation, which is described below, which the Monitoring Team concluded was not a late report. • Eight (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. Investigation 42831340 presented an unusual situation, which is described below, which the Monitoring Team concluded was not a late report. • For Investigation 42831340 the DFPS investigation concluded that the alleged incident did not happen. The reporter of the alleged incident named two alleged perpetrators and an approximate time of the alleged incident. One of the alleged perpetrators was not working on the day of the alleged incident. DFPS determined that the other named alleged perpetrator did not act inappropriately (based largely on video evidence) and returned an unconfirmed finding. Because DFPS found no evidence that anything inappropriate happened there would have been no reason to think that any other staff who were on duty in the home at the approximate timed of the alleged incident saw or heard anything that should have been reported. Consequently, the Monitoring Team determined that because of these circumstances there was no late reporting. Based on a review of five investigation reports included in Sample D.2: • Five (100%) showed evidence that unusual/serious incidents were reported	

#	Provision	Assessment of Status	Compliance
		within the timeframes required by DADS/Facility policy. • Five (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. The Facility did have a standardized reporting format. Based on a review of 13 investigation reports included in Samples D.1 and D.2, 13 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. Finally, in its last report the Monitoring Team noted that 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. During this review the Monitoring Team could see that the accuracy and completeness of the Facility's review of non-serious injuries continued to improve. This process serves as an added measure to detect non-serious injuries that should be reported to DFPS when the Facility's review of the injury could not rule out abuse and/or neglect as the cause, or a contributing factor, of the injury. Several examples where provided to the Monitoring Team showing how this review led to a report being made to DFPS. This process (while still needing continued improvement) is considered best practice. The Facility is to be commended for continuing this as it clearly demonstrates the Facility's commitment to client protection. Based on this review the Monitoring Team determined this Provision remained in compliance.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to	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 eight investigation reports included in Sample D.1, in each case where an alleged perpetrator was named the alleged perpetrator was removed from direct contact with individuals immediately following the Facility being informed of the allegation. Based on a review of eight investigation files included in Sample D.1 in no case was a staff person who had been removed from direct contact subsequently reinstated prior to the completion of the investigation, including review of the investigation findings by the Facility.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	individuals or the integrity of the investigation.	Based on a review of eight investigation files, it was documented that adequate additional action was taken to protect individuals in eight 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 remained in compliance.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The parties agreed the Monitoring Team would conduct a limited review of this Provision because the Facility has been in substantial compliance for consecutive reviews. The Monitoring Team reviewed sufficient documentation to ascertain continued compliance. The Monitoring Team reviewed staff development training reports that showed that the Facility was 100% current in abuse/neglect training and in unusual incident 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. Each response was evaluated by one member of the Monitoring Team, the Facility's QA Director, and the Facility's QA Program Analyst. Consequently, for each question 36 responses were evaluated (twelve Individuals' times three raters). Based on responses to questions, 12 direct support professionals provided satisfactory responses to the following questions as follows: "Describe two signs or symptoms of abuse." 36 of 36 responses were evaluated as satisfactory (100%). This compares to the compliance rate of 100% reported in the last review. "Describe two signs or symptoms of neglect." 36 of 36 responses were evaluated as satisfactory (83%). This compares to the compliance rate of 100% reported in the last review. "Describe two other types of serious incidents (other than abuse/neglect) that must be reported." Thirty-two of 36 responses were evaluated as satisfactory (89%). This compares to the compliance rate of 19% reported in the last review. The Facility has a process for checking staff competencies. Each month 10 staff, randomly selected, are quizzed by the Human Rights Office (HRO). If on the spot retraining is needed the HRO provides it. Data collected to these competency checks	Substantial Compliance

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		is maintained and a monthly summary is prepared and presented to the QA Director and the SA-PIC. Based on this review the Monitoring Team determined this Provision remained in compliance.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	The parties agreed the Monitoring Team would not monitor this Provision because the Facility was in substantial compliance for more than three consecutive reviews. This Provision remained in substantial compliance.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide 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 14 Individuals' ISPs (Sample D.3), 14 (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. QA monitoring conducted by the HRO also validated that guardians/LARs were mailed abuse/neglect information packets prior to the ISP meeting. It was evident to the	Substantial Compliance

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		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 reviewed minutes of self-advocacy meetings held since the last review. These are well attended (25-32 of the 63 Individuals living at the Facility) and abuse/neglect topics were reviewed at each meeting reviewed. Family members and LARs report frequent visiting. In the last customer satisfaction survey 79% of the respondents reported they visited at least once every three months; 58% reported they visited at least monthly. Four allegations of abuse or neglect were reported by Individuals or family members, further evidence that they are aware of their rights and exercise them. Based on this review the Monitoring Team determined this Provision remained in compliance.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	The parties agreed the Monitoring Team would conduct a limited review of this Provision because the Facility has been in substantial compliance for consecutive reviews. The Monitoring Team reviewed sufficient documentation to ascertain continued compliance. The Monitoring Team reviewed the system the Facility regularly uses (site inspections) to validate continued compliance with this Provision. The Human Rights Officer conducted a monthly inspection to ensure posters are properly displayed. The results of these inspections were reported to the IMC, QA Director, and presented to the SA-PIC. The Monitoring Team reviewed these reports (which showed 100% compliance) for each month since the last review. Based on this review the Monitoring Team determined this Provision remained 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.	The parties agreed the Monitoring Team would not monitor this Provision because the Facility was in substantial compliance for more than three consecutive reviews. This Provision remained in substantial compliance.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of	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.	Substantial Compliance

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	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.	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 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 Facility Director). 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 remained in compliance.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The Facility policy and/or procedures did define sufficient procedures to audit whether significant injuries are reported for investigation. Facility policy also required a trend review of incidents and injuries of those Individuals selected for audit each month. This review examined source documents and was very detailed looking for any patterns in types of injuries, causes of injuries, correlations of injuries occurring when certain staff were on duty, and whether any issues were detected that should cause an allegation to be referred to DFPS. The Facility had conducted audits at least semi-annually, during the preceding 13 months. The audits conducted were sufficient to determine whether significant resident injuries had been reported for investigation. No unreported significant injuries were identified by the audits. 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.	Substantial Compliance

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		Based on this review the Monitoring Team determined this Provision was in substantial compliance.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The parties agreed the Monitoring Team would not monitor this Provision because the Facility was in substantial compliance for more than three consecutive reviews. This Provision remained in substantial compliance.	Substantial Compliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The parties agreed the Monitoring Team would not monitor this Provision because the Facility was in substantial compliance for more than three consecutive reviews. This Provision remained in substantial compliance.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The parties agreed the Monitoring Team would not monitor this Provision because the Facility was in substantial compliance for more than three consecutive reviews. This Provision remained in substantial compliance.	Substantial Compliance
	(d) Provide for the safeguarding of	The parties agreed the Monitoring Team would not monitor this Provision because the	Substantial

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	evidence.	Facility was in substantial compliance for more than three consecutive reviews. This Provision remained in substantial compliance. In its last report the Monitoring Team noted that when an AP was placed on No Direct Care (NDC) status they signed an acknowledgment statement but this statement did not include a requirement such as "You are not to discuss the allegations or details of the investigation with anyone other than the investigators." This statement has been added to the Temporary Reassignment Notice. Additionally, in abuse/neglect training, and unusual incident training, staff is instructed to not discuss with each other any information regarding incidents under investigation. The Monitoring Team continues to have a significant concern that the Facility does not follow its own (and DADS) policy with respect to testimonial evidence. 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." The Monitoring Team found no evidence that would suggest this component of the Facility and DADS policy (separation of interviewees until they are interviewed) was being followed. In reviewing Sample D.1 (DFPS investigations) there was no indication that collateral witnesses had been physically separated pending interview. Facility QA data reported that DFPS witness interviews did not begin until at least day four following the report of the allegation in 50% of the cases. For 25% of the cases, interviews did not start until at least day seven. As a practical matter separation of witnesses would be difficult. The Facility and DADS should review its policy with respect to separation of interviewees until interviewed. DADS should provide guidance to the Facility as to how this policy should be implemented, or change the policy such that it establishes requirements that can be reasonably administered.	Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a	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 Director 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	Substantial Compliance

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	summary of the investigation, findings and, as appropriate, recommendations for corrective action.	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: • Eight of eight (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. • Eight of eight (100%) were completed within 10 calendar days of the incident, including sign-off by the supervisor; • Eight (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 two of the investigations reviewed, recommendations for corrective action were included. In two of the investigations (100%), the recommendations were adequate to address the findings of the investigation. <u>Facility Investigations</u> The following summarizes the results of the review of Facility only investigations: • Five of five (100%) commenced within 24 hours or sooner. All were commenced within one hour of being reported as the Facility had trained investigators on-duty 24/7. • Five of five (100%) were completed within 10 calendar days of the incident, including sign-off by the supervisor; • Five (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement.	

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		• In all five of the investigations reviewed, recommendations for corrective action were included. In all five of the investigations (100%), the recommendations were adequate to address the findings of the investigation. These typically included one or more IDT follow-ups documented in an ISPA, environmental changes, and when appropriate, personnel actions. Based on this review the Monitoring Team determined this Provision remained in compliance.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for	Based on the Monitoring Teams' review of DADS revised Policy 021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements. The Facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports. To determine compliance with this Provision 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 seven out of eight investigations reviewed (88%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. DFPS case 42875731 did not. This was an allegation that an injury "appears to be caused by a belt" and was sent back to the Facility as an administrative referral because an RN at the Facility offered the opinion that "she did not suspect the injury was the result of abuse" even though other testimony by Facility staff reported in the administrative referral reported "it (the injury) did look like a belt mark like the end of a belt" and "we (the staff) found a belt in his clothing drawer and the shape of the end of his belt looked like the shape on the right side of his waistline." Apparently DFPS chose to view this as an unknown injury report rather than an allegation of abuse, even though in the course of its preliminary investigation enough facts were brought forward indicating a likelihood that physical abuse may have occurred. The minutes of the regular quarterly meeting between the Facility and DFPS (9/11/13) to touch base on issues state "DFPS notes that if the MD is able to rule out abuse **or** if the individual did not make an outcry of abuse, then DFPS is not required to	Substantial Compliance

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	his/her conclusions.	investigate." In this case the alleged victim was nonverbal. In this case the medical person employed by the Facility was an RN who didn't even regularly work the home where the alleged victim lived and admitted in her testimony "I do not know (the alleged victim) well as I work on the other home." This allegation should have been subjected to a full investigation by DFPS and not sent back to the Facility as an administrative referral. Note: subsequent to receipt of this administrative referral the Facility conducted its own thorough investigation interviewing 20 staff and reviewing video, reaching a conclusion that it could not determine the cause of the injury. Because of the thoroughness of Facility follow-up this Provision remains in substantial compliance. Note: on the last day of this review by the Monitoring Team an administrative referral (case 42920805) was received by the Facility with somewhat similar circumstances. In this case the medical opinion that no abuse occurred was made by a hospital orthopedic surgeon who was treating the Individual for a serious fracture. Within the body of the administrative referral the DFPS investigator reports on video review which identifies a "big male" entering the alleged victim's bedroom at least once just prior to the Individual leaving his bedroom appearing in distress and pain in the opinion of the DFPS investigator reviewing the video. This allegation should have been subjected to a full investigation by DFPS and not sent back to the Facility as an administrative referral. As this was the last day of the compliance visit, the Facility had not yet determined how to respond to the referral. • The report utilized a standardized format that set forth explicitly and separately: o In eight (100%), each unusual/serious incident or allegations of wrongdoing; o In eight (100%), the name(s) of all witnesses; o In eight (100%), the name(s) of all alleged victims and perpetrators; o In eight (100%), the names of all persons interviewed during the investigation; o In eight (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 eight (100%), all documents reviewed during the investigation; o In eight (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating	

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		agency; o In eight (100%), the investigator's findings; and o In seven (88%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: • In five 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 unusual/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 unusual/serious incidents involving the alleged victim(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. Based on this review the Monitoring Team determined this Provision remained in compliance.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in	The Facility policy and procedures 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 Facility policy did require that any further inquiries or deficiencies be addressed promptly. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • The DFPS investigations in Sample D.1 did meet at least 90% compliance with	Substantial Compliance

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	the investigation and/or report shall be addressed promptly.	the requirements of Section D.3.e (excluding timeliness requirements) and D.3.f although one case in D.3.f which was problematic was thoroughly followed up on by the Facility; • Thirteen of 13 (100%) were reviewed by the Incident Management Coordinator and/or the Facility Director within five working days of receipt of the completed investigation. • The Facility Director/Incident Management Coordinator did accept at least ninety-four percent of the investigations over the six months prior to the onsite review. • For one of the DFPS investigation files (Sample D.1), the Monitoring Team noted problems with regard to Sections D.3.e, and/or D.3.f. Based on a review of the Facility's data, for this one investigation (100%), the Facility correctly noted the problems with the investigation and/or report, and while not returning the investigation to DFPS for reconsideration followed up appropriately by conducting its own thorough investigation.. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: • Five of five (100%) were reviewed by the Incident Management Coordinator within five working days of receipt of the completed investigation. • Five of five (100%) investigation files reviewed contained evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. • For four the supervisor had identified concerns. For these investigations, for four (100%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. Based on this review the Monitoring Team determined this Provision remained in 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-only investigations did meet the requirements outlined in Section D.3.f. Based on this review the Monitoring Team determined this Provision remained in compliance.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent	The Facility policy and procedures did require disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. In addition, the policy and procedures did specify the Facility system for tracking and documenting such actions and the corresponding outcomes.	Substantial Compliance

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	recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	For investigations reviewed in which disciplinary action was warranted prompt and adequate disciplinary action had been taken and documented in each instance. For investigations reviewed in which programmatic action was warranted prompt and adequate action had been taken and documented in each instance. For investigations reviewed in which disciplinary and/or programmatic action was taken there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified in each instance. This was achieved through the use of Corrective Action Plans (refer to Section E) and was closely monitored through the CAP data base. Based on this review the Monitoring Team determined this Provision remained in compliance.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	The parties agreed the Monitoring Team would not monitor this Provision because the Facility was in substantial compliance for more than three consecutive reviews. This Provision remained in substantial compliance.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The parties agreed the Monitoring Team would conduct a limited review of this Provision because previous reviews showed substantial compliance. The Monitoring Team reviewed sufficient documentation to ascertain continued compliance. For all categories of unusual incident categories and investigations, the Facility continued to maintain a system that allowed 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. Over the past two quarters, the Facility's trend analyses:	

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		▪ Were conducted at least quarterly; ▪ Did address the minimum data elements; ▪ Did use appropriate trend analysis procedures; ▪ Did provide a narrative description/explanation of the results and conclusions; and ▪ Did, as appropriate, contain recommendations for corrective actions. Based on a review of trend reports, IMRT minutes, and SA-PIC minutes, when a negative pattern or trend was identified and an action plan was needed, action plans were developed. As appropriate, action plans were developed both for specific individuals and at a systemic level. The trend reports and/or minutes showed that action plans were implemented and tracked to completion. The report/minutes showed review, as appropriate, of the effectiveness of previous action plans. The Facility continued to use its 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. Based on this review the Monitoring Team determined this Provision remained in compliance.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of	The parties agreed the Monitoring Team would not monitor this Provision because the Facility was in substantial compliance for more than three consecutive reviews. This Provision remained in substantial compliance.	Substantial Compliance

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	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.		

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 11/6/13 2. RGSC Action Plan 11/5/13 3. RGSC Section E Presentation Book 4. DADS Policy 3.1 Quality Assurance 5/22/13 5. RGSC SOP QM 100.001 Quality Management Department (6/13) 6. RGSC SOP QM 100.14 DADS Quality Assurance Expectations (8/13) 7. RGSC SOP HR 100-07 Compliance With Required Training/Performance Evaluations/Corrective Action Plans/Health Information Management Deficiencies Requiring Action (2/13) 8. RGSC Quality Assurance Plan 10/16/13 9. RGSC Improving Organizational Performance Program 11/1/13 10. Settlement Agreement Performance Improvement Council (SA-PIC) meeting minutes (including extensive attachments) for 5/13 through 9/13 11. RGSC Monthly Trend Analysis Report 9/30/13 12. RGSC Quarterly Trend Analysis Report 9/30/13 13. RGSC Injury Logs (witnessed and discovered) 5/18/13 to 11/18/13 14. Corrective Action Plan (CAP) Reporting from 5/1/13 to 9/30/13 15. Sample of completed SA monitoring tools 16. Incident Management Review Team (IMRT) minutes for meetings on 7/22, 7/29, 8/5, 8/12, 8/19, 8/26, 9/3, 9/9, 9/16, 9/23, and 9/30/13 17. Self-Advocates meeting minutes 6/26, 7/31, and 8/28/13 18. Sample of 15 CAPs 19. Sample of CAP initiation audits 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) 11/20/13 2. Settlement Agreement Performance Improvement Council (SA-PIC) 11/21/13
	Facility Self-Assessment: 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: 1. 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: a. The monitoring/audit tools the Facility used to conduct its self-assessment included the Statewide DADS tools supplemented with some additional Facility specific tools. b. These monitoring/audit tools included indicators to allow the Facility to determine compliance with the Settlement Agreement. c. The monitoring tools included adequate methodologies, such as observations, interviews, record reviews, and data review. d. 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. e. The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results and the Facility had not implemented any inter-rater reliability into its QA system. f. 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). g. Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. 2. 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. 3. The Facility presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: a. Presented, for many sections of the SA**,** findings based on specific, measurable indicators. b. Measured, for many sections of the SA**,** the quality as well as presence of items. c. 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, organized and presented in a meaningful way, and inter-rater reliability was absent. Additionally, 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. 1. Actions were reported as completed, in process, or not started. 2. The Facility data identified areas of need/improvement. For example, in Provision E.1, an action step was to develop an inter-rater reliability policy detailing the inter-rate process in an effort to increase the validity and reliability of data collected. The actions did provide a set of steps likely to lead to compliance with the requirements of this Section.

	Summary of Monitor's Assessment: Since the last review the Facility had updated its Quality Assurance policy and its Improving Organizational Performance Program document to include key indicators. While key indicators had been identified, and for most at least some data was being collected, this was a very new initiative requiring much refinement. CAP initiation audits, CAP completion audits, and CAP effectiveness audits continued to be used to measure the efficacy of the QA system. The Facility had initiated several administrative action steps to close the large number of its outstanding CAPs. This had proved effective in reducing the number of open CAPs with long expired due dates. The majority of CAPs (including those designated as high priority) were not completed timely but at least for now most are closed (i.e. completed). In its last report the Monitoring Team noted that 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 Monitoring Team could see that this policy had been implemented. The implementation of QA processes at the Facility was variable department to department but to a lesser degree than that observed at the last review. Most CAPs continue to come from IMRT meetings. Most CAPs continued to focus on single issues related to employee performance. At the last review it was reported that the Facility was taking action through a CAP reduction initiative to better define circumstances where a CAP is an appropriate mechanism for corrective action planning. This did not appear to occur. Additionally, there was only limited evidence that the QA process has resulted in the identification of systemic issues requiring resolution. The Facility collected data that was tracked for most provisions of the Settlement Agreement; however, data collection, reporting, and trending were not consistent in all areas of the ICF-IID program. Trend analysis was evident for many sections of the SA, but this trend analysis did not always present and organize information in a way that would be meaningful and understandable to those responsible for oversight (SA-PIC). At this time, the data system developed by the Facility was being used more for management oversight and performance accountability than for performance improvement purposes. The SA-PIC routinely met twice a month. One meeting was referred to as the "business meeting" and the other meeting was referred to as the "action plan meeting." Detailed agendas and minutes were maintained for the "business meeting". Such was not the case for the "action plan meeting." In its last two reports 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. The data system developed by the Facility is flexible and was being used more for management oversight and performance accountability of individualized employee performance issues rather than as support for identifying broader more encompassing issues needing attention.

	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.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	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 committees. Neither was in place at this time.	Noncompliance

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		Facility QA policies and practices The Facility had updated its Quality Assurance policies since the last review. The Facility has two policies that taken together constitute their QA policy. One is titled "DADS Quality Assurance Expectations" which for the most part mirrors the State policy. The second is titled "Improving Organizational Performance" and provides an overall description of Facility wide plans including a management plan, environment of care plan, emergency operations plan, and information management plan. The Improving Organizational Performance policy also described the membership and responsibilities of the Governing Body, Executive Leadership Team, Performance Improvement Council, Medical Executive Committee, Professional Staff Organization, and the Settlement Agreement Performance Improvement Council (SA-PIC). These facility policies adequately supported the state policy for quality assurance. The Settlement Agreement Performance Improvement Council (SA-PIC) performed the same functions as the Quality Assurance/Quality Improvement (QA/QI) Council required by State policy. The SA-PIC routinely met twice a month. One meeting was referred to as the "business meeting" and the other meeting was referred to as the "action plan meeting." Detailed agendas and minutes were maintained for the "business meeting". Such was not the case for the "action plan meeting." The Facility reported the action plan meetings had only recently been initiated and were intended to review and analyze SA data, by section, and determine, based on data review, if systemic Corrective Action Plans should be initiated. The Monitoring Team was provided with what the Facility characterized as "notes" related to the two meeting held however these were insufficient to determine if these meetings accomplished their intended purpose. The agendas of the "business meeting" included regular review of some sections of the SA, primarily Sections C and D. The Monitoring Team noted that the Facility was able to produce volumes of what was characterized as QA related data but it was often difficult to determine its relevance to a particular SA section. There was little consistency in the formatting of various reports. Reports often had rows and/or columns labeled in such a way that only the principle user of the report could easily understand. This made it difficult for the Monitoring Team to review report data, and presumably would make it difficult for the "occasional user" (including the SA-PIC) at the Facility to do the same. The Facility acknowledged that there was a need to better organize the presentation of data for review and analysis. The Facility collected data that was tracked and trended for most provisions of the Settlement Agreement. The QA Plan matrix did not show any data collected for Sections G and H of the SA. The QA Plan matrix showed data collected, reported and analyzed for 92 separate reporting categories across 17 of 19 SA sections. Data collection, reporting, trending, and analysis were most complete and comprehensive for various reports	

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		associated with Section C (restraints) and Section D (abuse, neglect, exploitation and incident management). Data collection, reporting, and trending for the key indicators developed by the Facility was just getting started. The Key Indicators matrix presented to the Monitoring Team showed 288 distinct data reports associated with all 19 sections of the SA. These key indicators needed refinement as in their present form they merely establish counts of various events, such as the number of persons receiving an older generation of psychotropic medication, or the number of persons with occupational related training programs. There was a complete and adequate data list/inventory at the Facility and this list was current. As noted above, the Facility needs to improve the organization of data, report formatting, and relate each data report to the SA section it relates to. In its last report the Monitoring Team noted that the QA plan narrative at the Facility was not comprehensive in that it did not include provisions for inter-rater reliability. This was still the case. The Facility acknowledged this as a significant issue with its QA process. In its last report the Monitoring Team noted that the Facility reported it was 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 Monitoring Team found no evidence that this had occurred. The Facility did not have one document which could be considered the QA Plan narrative. 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 in these three documents appeared to include the essential components of a good QA Plan. In its last report the Monitoring Team suggested that in the future, the Facility may want to consider consolidating information into one document. The Monitoring Team continues to believe doing so would make the QA plan/process at the Facility more understandable. Such a document would at least summarize: 1. a description of the purpose of the QA program, 2. the organizational structure of the QA process (including individual roles and responsibilities), 3. the data list/inventory, 4. the QA matrix, 5. key indicators used at the Facility, 6. a description of how data are summarized and analyzed,	

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		7. a description of the role of other clinical and operational departments in QA, 8. description of workgroups/Performance Improvement Teams, 9. the QA report, 10. a description of the SA-PIC and its role in reviewing data and guiding the entire QA process, and 11. description of the corrective action plan (CAP) process The Monitoring Team asked the Facility to review the above referenced three documents and point out where in these documents the above 11 items could be found. All were present in some form but were not uniformly presented in a QA Plan narrative. 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 SA-PIC. These data had limitations. There was no inter-observer reliability and as noted above the "action plan meeting" of the SA-PIC did not document any of its deliberations and decisions in meeting minutes. For the 20 sections of the Settlement Agreement, a set of key indicators were included for all of the 20 sections (100%). Many, as presented in the QA Plan Matrix, were not adequate. In reviewing the list of 200+ key indicators the Monitoring Team noted that many items represented only data to be collected (e.g. number of restraint documentation completed correctly, or, number of CAPs opened/closed monthly) without any corresponding percentages or other indication of what was being measured beyond numerical changes month to month. 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 380 items in the QA plan matrix, 358 (94%) were submitted/collected/received by the QA department for the last two reporting periods for each item (e.g., monthly, quarterly). Examples of reports not submitted/collected/received included that did not included data related to psychological assessments, performance improvement measures, nursing assessments, medication room monitoring, and health information management delinquency audits. Of the 380 items in the QA plan matrix, only 70 (18%) 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 recent introduction of key indicators represented 288 of the 380 (76%) of the items in the QA Plan Matrix, with 92	

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		non-key indicator items. Key indicator data had not been reported for a long enough period to identify, analyze, and take action to address trends. Therefore, the 70 items that were documented to show review or analysis were out of 92 (76%) non-key indicator items for the last two reporting periods for each item (e.g., monthly, quarterly). The Facility probably has too many items identified in its QA Plan Matrix. The Facility acknowledged this and noted that accrediting organizations have sometimes noted the Facility was "data rich" to the point meaningful analysis was difficult. The ICF population at the Facility was less than 65. It would appear the Facility could organize its QA process targeting the issues most compelling to those Individuals living at the Facility. 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 63 self-monitoring tools used for the SA sections, (a) the content of 63 (100%) appeared to be appropriate and (b) 63 (100%) were reviewed within the past six months, and revised as appropriate. This review occurred as each SA Section Lead reviewed the introduction of key indicators and modified monitoring tools, where appropriate, with data needed for the key indicators. The self-monitoring tools themselves were not key indicators. Of the 63 self-monitoring tools for the SA, 24 (38%) had adequate instructions for the user. None of these instructions were in written form. They were considered adequate since the users had implemented them correctly and they had been in use for a considerable period of time. The Facility reported it would be working on developing written instructions for monitoring tools. 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 G & H. Since the last onsite review, of the 19 sections of the SA, the Facility reported 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 19 (100%) of the 19 sections. This was reported to have occurred at the SA-PIC meetings; however, as noted earlier minutes of many of these meetings were not kept so the Monitoring Team could not verify the Facility report relative to this subject. Based on this review the Monitoring Team determined this Provision was not in	

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		compliance. 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 comprehensive (perhaps overly comprehensive) 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 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.	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. The Monitoring Team noted inconsistency in how this occurred SA section to SA section, and within reports associated with a SA section. As noted in Provision E.1 it was often difficult to determine a reports relevance to a particular SA section. There was little consistency in the formatting of various reports. Reports often had rows and/or columns labeled in such a way that only the principle user of the report could easily understand. This made it difficult for the Monitoring Team to review report data, and presumably would make it difficult for the "occasional user" (including many SA-PIC members) at the Facility to do the same. The facility acknowledged that there was a need to better organize the presentation of data for review and analysis. Data from the QA plan matrix for one of the 19 (5%) sections of the SA (not section E) 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 as yet 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 19 of the 19 (100%) sections of the SA. As reported in the last review, 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	Noncompliance

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		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); Pharmacy &Therapeutics (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. These committees are collectively referred to as "reporting teams." 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 part of their regular agenda. Since the last onsite review, during all (100%) of the SA-PIC 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 SA-PIC meetings, at least some data were reviewed and analyzed. Since the last onsite review, during all (100%) of the SA-PIC meetings, at least some action plans (CAPs) were created for systemic problems and for individual problems. Since the last onsite review, a facility QA report (for dissemination at the Facility and for presentation to the SA-PIC) was created for each monthly SA-PIC business meeting. As reported earlier in this report, there is also a monthly SA-PIC Action Plan meeting for which minutes were not kept. Minutes of the business meeting reviewed by the Monitoring Team and observation of the meeting held during this review showed that QA reporting was not typically associated with Settlement Agreement sections/topics. In	

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		fact, it was more likely to be organized around the reporting teams established as part of the Facility's performance improvement program. While an acceptable practice it may be easier for the Facility to monitor progress towards compliance with the SA if QA reporting was organized, at least in part, around specific SA requirements, section by section. Of the 20 sections of the SA, 20 (100%) appeared in a QA report at least once in each quarter since the last onsite review. Of the sections of the SA that were presented, none (0%) contained all the following components: • Self-monitoring data o Reported for a rolling 12 months or more (all 19 sections included this) o Broken down by program areas, living units, work shifts, etc., as appropria (only Section D reported this level of data delineation) • Key indicators o Reported for a rolling 12 months or more (performance data for key indicators was generally missing) o Broken down by program areas, living units, work shifts, etc., as appropriate (only Section D reported this level of data delineation) • Narrative analysis (all 20 sections included some form of narrative analysis) There was not an adequate description of the SA-PIC in the RGSC policy Quality Assurance Expectations and the RGSC policy Improving Organizational Performance Program. For example, neither document clearly delineated the scope of responsibilities for what the Facility characterized as the SA-PIC business meeting (which met one time a month) from the SA-PIC action plan meeting (which also met one time a month). Since the last onsite review, the SA-PIC did meet at least once each month. Minutes from all five (100%) SA-PIC business meetings since the last review indicated that the meeting occurred according to schedule. Minutes from the SA-PIC action plan meetings were not available so the Monitoring Team could not determine if they had occurred according to schedule. Minutes from all five (100%) SA-PIC business meetings since the last review indicated that the agenda included relevant and appropriate topics. Minutes from the SA-PIC action plan meetings were not available so the Monitoring Team could not determine if they included relevant and appropriate topics.	

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		Minutes from all five (100%) SA-PIC business meetings since the last review indicated that there was appropriate attendance/representation from all departments. Minutes from the SA-PIC action plan meetings were not available so the Monitoring Team could not determine if there was appropriate attendance/representation from all departments. Minutes from all five (100%) SA-PIC business meetings since the last review documented that (a) at least some data from QA plan matrix were presented, (b) in some cases the data presented were trended over time, (c) comments/interpretation/analysis of data were presented. Minutes from the SA-PIC action plan meetings were not available so the Monitoring Team could not determine if 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 all five meetings (100%) SA-PIC business meetings, recommendations, and action plans were developed when appropriate to do so, and were based on the data presented. Minutes from the SA-PIC action plan meetings were not available so the Monitoring Team could not determine if recommendations and action plans were developed when appropriate to do so and were based on the data presented. During a SA-PIC business meeting observed by the Monitoring Team, there was active participation of participants other than the presenter of reports/data presented during the meeting. It did not appear that any of the discussion led to the development of an action plan or a CAP. 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 particular staff persons. In its last report the Monitoring Team noted that the Facility reported it 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; however, from reviewing logs of open and closed CAPs it appeared that most CAPs were still directed at employee performance and training issues rather than more encompassing systemic issues. Even for those CAPs labeled "systemic," many dealt primarily with employee performance issues. For example, open systemic CAP 1931 directed the Program Improvement Manager to ensure that secondary investigations related to nine Individuals got completed. This type of CAP really does not aim at system improvement but instead at resolving a specific deficient case (in this instance, completion of several individual and specific cases). A truly systemic issue might have been "secondary investigations are not being completed correctly and timely" followed by a series of action steps intended to increase the frequency in which the secondary investigations are completed correctly and timely. Open systemic CAP 1991 was addressing one Individual for whom a rights	

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		assessment had not been turned in. If timely completion of rights assessments is a systemic issue, a CAP should identify it as such and include baseline data from which improvement (related to CAP action steps) can be measured. This would allow performance related to this issue/problem to be tracked over time and addressed as needed until an acceptable performance is maintained. 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 the Facility might be better served by restructuring CAP criteria. Of the 15 CAPs reviewed by the Monitoring Team, 15 (100%) appeared to appropriately address the specific problem for which they were created. As described above, these CAPs typically addressed employee performance issues, For example, CAP 2123 was put in place because one employee did not follow through with an IMRT recommendation. CAP 2142 was put in place to direct a home manager to take administrative action with one employee. Many of the CAPs in this sample were not filled out completely, often not recording whether the CAP was intended to address a systemic or individualized issue, the level of urgency, frequency of monitoring, and expected outcome. While the Facility had a basic framework in place for CAP management, data reviewed presented to the Monitoring Team suggests ineffective oversight of the process. This may be the result of too many CAPs directed at managerial oversight functions rather than significant programmatic and clinical systemic trends. Based on a sample of 15 CAPs: • 15 (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. • 6 (40%) included the anticipated outcome of each action step (many CAPs had only one action step, for example, retraining a specific employee). • 15 (100%) included the person(s) responsible for implementation. • 15 (100%) included the time frame in which each action step must occur. The tracking of CAPs at the Facility was well designed and flexible. At the time of CAP initiation, each CAP was designated as "emergent" (must be completed within 24hrs), "high priority" (must be completed within one week), or "low priority" (must be completed within two weeks or as noted on the CAP). CAPs are coded in such a way that reports can be prepared and used for managerial oversight and accountability. For example, CAP reports can be prepared that display: 1. Open CAPs sorted by emergent, high priority, and low priority and reporting team responsibility. It is also possible to sort open CAPs by individual staff person assigned responsibility for each CAP. CAPs had not been coded in a way that ties	

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		them back to SA sections but a recent change now made this possible. 2. Closed CAPs sorted by emergent, high priority, and low priority and reporting team responsibility. It is also possible to sort closed CAPs by individual staff person assigned responsibility for each CAP. 3. High priority open CAPs whose completion is delinquent by more than 30 days (or any other time oriented variable). 4. Low priority 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 can be very useful for management oversight and performance accountability. Based on this review the Monitoring Team determined this Provision was not in compliance. 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 15 CAPs, all 15 (100%) included documentation about how the CAP was disseminated, all 15 (100%) included documentation of when each CAP was disseminated, and all 15 (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.	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 15 completed CAPs, 14 (93%) were implemented fully and nine (60%) were implemented in a timely manner. As reported earlier in Provision E.2 most CAPs were directed at a single instance of employee or IDT performance. Consequently action plans typically consisted of one action. Most action plans were not complicated and did not involve multiple action steps involving multiple departments or disciplines. The Facility acknowledged that timely CAP completion is a problem which is subject to monthly auditing. QA data reflecting these monthly audits showed timely completion rates of 20% in May, 22% in June, 30% in July, 60% in August, and 30% in September. The majority of CAPs (including many designated as high priority) were not completed timely. In reviewing a report prepared by the Facility of all CAPs closed in October, 2013 44 of 52 (85%) of high priority CAPs were closed late an average of 80 days. 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	Noncompliance

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		problem originally identified, the Facility had initiated CAP Effectiveness Audits. QA data reflecting these monthly audits showed an average of 87% of CAPs having been determined to be effective. As reported earlier in Provision E.2 most CAPs were directed at a single instance of employee or IDT performance. Consequently effectiveness determination typically consisted of validation that a single action (e.g. completion of retraining or the IDT met) had occurred. Most CAPs did not adequately define the issue/problem requiring attention and action plans did not define an anticipated outcome (e.g. fewer incidents where employees need retraining). The data system developed by the Facility is flexible and was being used more for management oversight and performance accountability of individualized employee performance issues rather than as support for identifying broader more encompassing issues needing attention. As noted in its last report the Monitoring Team reported that 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. This policy had been implemented and timely completion of CAPs had improved from that reported in the last review. Additionally, the Monitoring Team did find evidence of action taken with employees pursuant to this policy. While 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, there is a significant problem in properly describing the issue(s) a CAP is intended to correct. The Facility is also to be commended for 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 business 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 SA-PIC monthly. As noted in the previous reviews, to achieve compliance, the Facility must ensure CAPs	

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		designated as emergent or high priority 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.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	For 15 of 15 CAPs (100%), documentation showed review of their effectiveness (i.e., outcomes), and for 15 of 15 CAPs (100%), documentation showed review of their timely completion. While 100% of the 15 CAPs in the sample were reviewed for effectiveness the Facility was not addressing any underlying issues associated with what were primarily employee performance issues being addressed individually with the affected employees. None of the 15 CAPs in the sample (and likely very few overall) required modification primarily because the vast majority of CAPs were directed at a single instance of employee or IDT performance. Consequently action plans typically consisted of one action. Most action plans were not complicated and did not involve multiple action steps involving multiple departments or disciplines. The effectiveness of CAPs, for the most part, merely consisted of whether or not the intended action occurred. As reported in its last report the Monitoring Team noted that the Facility had initiated and maintained a process for CAP Effectiveness Audits. Ten CAPs per month had been subjected to this audit process; however, as noted above, limitations in design of a CAP (the definition of issues to be addressed), and the absence of multiple action steps intended to improve system performance and/or minimize reoccurrence of the same types of issues needing correction, allows this effectiveness audit to only determine primarily if an intended action occurred or did not occur and not whether the action was effective at remedying or reducing the identified problem. The Facility reported that it was modifying its approach to effectiveness audits limiting these audits in the future to systemic CAPs that had been closed for at least two months. It was felt this would facilitate better measurement of effectiveness. Based on this review the Monitoring Team determined this Provision was not in compliance.	Noncompliance

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 11/6/13 2. RGSC Action Plans 11/5/13 3. Presentation Book Section F 4. DADS Policy 004.1 Individual Support Plan Process and attachments (11/20/12) 5. DADS Policy 017 Habilitation, Training, Education, and Skill Acquisition Programs 8/1/13 6. RGSC Standard Operating Procedure (SOP) ICF-IID 600-01 Individual Support Plan Process (August 2012) 7. Individual Support Plans (ISPs) and Supporting Documentation for Individuals #48 and #143. 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. 8. Monthly reviews for Individuals #48 and #143, May 2013-October 2013 9. Individual Support Plan for quarterly review for Individual #79 10. Settlement Agreement Section F monitoring tool blank 11. List of QIDPs with their current assignments (i.e., the residence(s) to which they are assigned), and the number of individuals on their caseloads. 12. Any tools used to measure QIDP competency with regard to (a) the facilitation of ISP meetings; and (b) the writing of ISP documents. 13. List of QIDPs who have been deemed competent. 14. "PSP Attendance—PSP's only" table for 5/1/2013-9/30/2013 and for each month during that period 15. Documents provided for Settlement Agreement-Program Improvement Committee meeting of 11/21/13, including: a. Monthly Attendance by Discipline 6/1/13-10/31/13 PSP's only b. PSP Attendance-PSP's only 6/1/13-10/31/13 c. Overall Facility Attendance Compliance PSP's only 6/1/13-10/31/13

	d. Table of ISP dates and timeliness 6/1/13-10/31/13 e. Assessment Reports for July, August, and September 2013 f. ICF Monthly Delinquency Report from Health Information Management (HIM) for October 2013 audit including assessment compliance graphs g. Bar graph of Overall Facility Attendance Compliance PSP's only 6/1/13-10/31/13 16. 2013 Assessment Report for newly admitted individuals from July 2013-November 2013 17. ISP Assessments Tracking Log May 2013-September 2013 18. Any monitoring tool used by the facility to assess the quality of the ISP and the ISP meeting, and any reports subsequently issued with the findings and/or recommendations. No reports were provided for review. 19. The last 10 Section F monitoring tools completed by the: a. QDDP Coordinator; and b. Quality Assurance Department Staff. 20. ISP Monitoring Form 9/1/13 21. ISP Meeting Guides for annual ISP planning meetings for Individuals #74 and #84 22. ISP Meeting Guide and assessments completed for Admission ISP meeting for Individual #28 23. ISP Preparation Meeting report for Individual #66 24. Alphabetical list of each individual at the Facility, with the most recent ISP meeting date, the date the ISP was completed/filed, and the date of the previous ISP meeting 25. List of individuals admitted to the Facility and date of admission **People Interviewed:** 1. Joint Interview Juan Miguel Gonzalez (Program Improvement Coordinator), George Romero (QDDP Manager), Rosa Sanchez (Quality Assurance), and QIDPs Karina Serratos, Rebecca Olivarez, Daniel Perez **Meeting Attended/Observations:** 1. ISP Annual Planning Meetings for Individuals #74 and #84 2. Admission ISP meeting for Individual #28 3. Quarterly review for Individual #79 4. ISP Preparation (Pre-ISP) meeting for Individual #66
	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 monitoring/auditing tools. o Although this was not reported specifically in the Self Assessment, it appeared much of the information for numerous provisions came from data on the ISP Monitoring Tool. No further information was provided about who completed the tool, whether there were or were not instructions, or whether reliability had been established on ratings on this tool. o The QE Coordinator used the "SA monitoring tool for Section F"; the following information

	relates only this this monitoring tool. o This monitoring/audit tool included adequate indicators to allow the Facility to determine compliance with some of the Section F requirements of the Settlement Agreement. o It was unclear whether the monitoring tools include adequate methodologies, because the Self Assessment and the sample of monitoring tools provided to the Monitoring Team did not indicate whether all ratings were established from review of ISPs or also included other methodologies such as interview and observation. o The Self-Assessment identified the sample(s) sizes (one case per quarter), but did not state the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population. o There was no way to determine whether the monitoring tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results; however, as reported in Provision F2g, the percentages of compliance identified in the Self Assessment was not consistent with the findings of the Monitoring Team. o The following staff/positions were responsible for completing the audit tools: QE Coordinator and QIDP Manager o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools. Again, the ratings by both these raters were inconsistent with the Monitoring Team's findings. Please see Provision F2g for more information. ▪ Used other relevant data sources and/or key indicators/outcome measures. Measures included, among others: o From a sample of ISPs, percent that met a variety of criteria such as: ▪ Whether the ISPs were facilitated by a QIDP ▪ Whether the ISPs addressed all recommendations ▪ Whether ISPs used assessments to develop action plans ▪ Whether ISPs showed actions/skill acquisition plans that encouraged community participation o Percent of IDT meetings for which assessments were posted on the shared drive 10 working days prior to the meetings ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Presented findings consistently based on specific, measurable indicators, except that the data from the Section F monitoring tool were overall percentages that did not indicate what specific requirements were and were not met, nor any analysis of the data o Consistently did not measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline, except for the Section F monitoring tool. ▪ The Facility rated itself as being in compliance with the following provisions of Section F: Provisions F2a1, F2a4, and F2a6. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with no provisions of this Section. Regarding Provision F2a1, barriers to living in a more integrated setting were not adequately identified and

	addressed in the sample of ISPs reviewed by the Monitoring Team. For Provision F2a4, the action plans in the ISPs did not specify timeframes for completion, and the identification of persons responsible was by position, not by individual. For Provision F2a6, the ISPs reviewed consistently identified the data to be taken as "Progress Note" but did not indicate what data would be gathered from the progress notes and use to assess progress. 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. Interestingly, one action identified as Not Started was assessment of QIDP competency. The information in response to the document request reported that all QIDPs had been assessed for competency. The Facility should ensure information provided to the Monitoring Team is accurate and consistent. Several In Process actions appear to involve procedures that have been put in place and are ongoing; these would better be described as Completed, and a new action put in place to monitor their continuing implementation. ▪ The actions did not consistently provide a set of steps likely to lead to compliance with the requirements of this Section. Although the actions seemed reasonable, many appeared to need a better-defined set of steps. For example, an action for Provision F1c to develop programs for individuals which include their strengths and preferences is a good action, but there is no indication of what action steps will be needed to make this happen (especially given that the monitoring tools provided to the Monitoring Team indicate this already happens almost uniformly, a finding inconsistent with the Monitoring Team's finding).
	Summary of Monitor's Assessment: Although not yet in compliance with any provision of this Section, RGSC has continued to progress toward meeting the requirements. Improvements had occurred in the ISP planning processes. Improvements had occurred in completion of both routine assessments and assessments in response to significant changes in an individual's status, but continuing improvement is needed. The interdisciplinary teams still need to make significant improvements in identification of needed services and supports, development of actions and goals to address those services and supports, and identification of barriers to movement to more integrated settings. The QIDP was the identified facilitator for the ISP process that develops, monitors, and revises treatments, services, and supports. The QIDP led ISP meetings. Although individuals were not assisted to lead their own meetings, the QIDP and other IDT members encouraged individuals to participate in decisions. Although attendance at ISP annual planning meetings was variable across disciplines, it did appear to be improving. Completion of assessments in advance of the ISP annual planning meeting and Admission ISP meeting was also variable. Improvement in timeliness continues to be needed. Completion of assessments in response to a change in status was more timely, in part due to the post hospitalization assessment process, and in

	part perhaps due to the interaction and information provided through the Morning Medical Report meetings. Quality and adequacy of assessments was also variable across disciplines. As with timeliness and quality of assessment, the use of information from assessments varied. Information from Integrated Risk Review Forms, OT/PT assessments, and Structural and Functional Assessments were regularly used in development of skill acquisition and behavioral intervention programs. There was little evidence that information from the Functional Skills Assessment was considered in developing skill acquisition programs. Assessments did not consistently include a determination of whether the individual could be served in a more integrated setting or of the protections, services, and supports the individual would need. Without that, it is difficult to identify obstacles to transition, because it is unclear which necessary supports are and are not available from providers. When barriers were identified, they did not always lead to goals, objectives, or services strategies. The ISP did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his/her needs. Review of a small sample of ISPs indicated the ISPs did not include a full complement of individualized goals or objectives and/or strategies to address the array of supports and services the individual required. The IDTs did not consistently develop such a comprehensive complement of individualized goals and objectives that were relevant to and likely to lead toward attainment of outcomes related to each preference, meet identified needs, and overcome barriers to living in the most integrated setting. ISPs reviewed did not clearly state observable and measurable goals and objectives, nor the methods for implementation. Presumably, these would be stated more clearly in the descriptions of the programs and interventions, but it is important the IDT members are aware of the specific services to be provided and how progress will be measured. There were signs of improvement in integrated planning. However, the lack of timeliness of assessments inhibits the ability of IDT members to review them in advance of the meeting. Information needed by IDT members for collaborative decisions was not always available at the planning meetings. Integrated Health Care Plans were not sufficiently integrated among all relevant disciplines. Observations and interviews found that services and supports listed in the ISP were not always implemented, and staff responsible for implementation were not consistently familiar with the programs to be implemented. A process for competency-based training for staff responsible for implementation of treatment plans had been implemented, but it was implemented too recently to assess effectiveness.

	QIDPs were documenting monthly reviews, although not consistently. However, these reviews did not provide evidence of progress evaluation or program modification. Furthermore, most responsibility for reviews was assigned to the QIDP. There was little evidence that appropriate clinicians reviewed the progress of individuals on clinical services and supports. The Facility had a monitoring system for the quality of ISPs. However, the findings of audits were inconsistent with the findings of the Monitoring Team. Thus, it was unclear that the monitoring process engaged in by the Facility accurately identified areas needing improvement and led to action.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	<u>Assignment of a Facilitator and Staffing of QIDP Department</u> The Facility assigned the Qualified Intellectual Disabilities Professional (QIDP) as the one person to facilitate the work of the Interdisciplinary Team (IDT) for each individual and ensure that team members participate. The Facility had four QIDPs. This produced caseloads of 15-17 individuals, a reasonable number. Each individual had an assigned QIDP. The Facility reported that there had been no change in the process for determining that the QIDP was competent at facilitation and at writing the ISP documents. The Facility used the Q Construction Facilitation curriculum for training in this area and for evaluating competence. The Facility reported all four QIDPs had been deemed competent. An annual competency recertification check had been done for the three QIDPs who had been at the Facility, and a new QIDP was certified as competent. Staffing also included a QIDP Manager, who supervises the QIDPs. Observation at two annual ISP planning meetings and the 30-day admission ISP planning meeting confirmed that the QIDP was the team leader responsible for ensuring team participation and facilitating involvement of IDT members. DADS policy 004.1 requires the QIDP to assist the individual (and LAR, as appropriate) in leading the team in an interdisciplinary discussion. Although individuals were not assisted to lead their meetings, they were encouraged to participate, and both participated actively. In addition, both LARs also participated actively.	Noncompliance

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		Substantial effort had been made to improve the ISP planning process; improvements had occurred in the ISP planning processes and the ISPs but these still required significant improvement. For example: • Individual #74 was present at the annual ISP planning meeting, and Individual #28 was present at the Admission ISP meeting. The QIDP ensured the individual at both meetings was encouraged to participate actively. • At neither of the two meetings observed did the facilitation process result in addressing all significant needs and preferences. o As reported in Provision L1, the Monitoring Team was impressed that the psychiatrist addressed all relevant clinical issues. However, there were several medical conditions for which the IDT should have put a plan in place to review, and about which there was little to no discussion at the planning meeting. • ISPs did not consistently address all significant needs and preferences. o As reported in Provision P1, assessments had improved; they did not yet consistently identify potential to develop new functional skills or describe current motor skills and activities of daily living and how these skills were utilized throughout the day. o As reported in Provision S1, it was not clear that findings of the Functional Skill Assessment (FSA) had been effectively used in the development of skill acquisition programs or that the FSA was revised as indicated by data from training. For example, Individual #145 was provided a skill acquisition plan (SAP) for handwashing although the FSA indicated that the individual was independent in washing hands. o For neither of the two (0%) ISPs reviewed did the facilitation process result in an adequate discussion of the most integrated setting. See Provisions F1e and T1b1. o For neither of the two (0%) ISPs reviewed did the facilitation process result in an ISP that provided evidence of adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. The assigned QIDP also remained responsible for ensuring the monitoring and revision of treatments, services, and supports. The Monitoring Team found the QIDP did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed, as described below under Provisions F2a6 and F2d. <u>Conclusion</u> Although the Interdisciplinary Team (IDT) was facilitated by one person from the team	

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		(the QIDP), the QIDP 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> DADS Policy 004.1 clearly identified requirements for team composition, attendance, and participation. During the ISP Preparation meeting, the IDT was to identify the required participants at the annual ISP planning meeting. At the ISP preparation meeting for Individual #66, the IDT members who would be required to attend the annual ISP planning meeting for this individual were identified. The Facility tracked the attendance of IDT members at annual ISP meetings. The Facility provided an Attendance Tracking Log for April 2013-May 2013. The Facility reported it had switched to a new ISP process monitoring database but found problems with the report. Nevertheless, the Facility also provided documents titled "PSP Attendance—PSP's only" for 5/1/2013-9/30/2013 and for each month during that period, and the same document for 6/1/13-10/31/13. These tables listed the meetings required by each team member, the number attended fully or partially in separate columns, and the percent compliance. The Self-Assessment (apparently using data from the table for the period of 5/1/13-9/30/13) reported that 81% of required IDT members were present at the 29 ISP meetings held 5/1/13-9/30/13. The Self-Assessment included a breakdown by team members, including individuals, QIDPs, representatives from direct care, and various clinicians. Attendance of required team members ranged from 4% for physicians (the only discipline with attendance lower than 69%) to 100% with a QIDP present and the Placement Coordinator or Transition Specialist present; a psychology assistant or behavior analyst was present at 100% of 27 ISP meetings for individuals receiving psychology services, and the Human Rights Officer (HRO) was present at five of five meetings required. Some departments/disciplines did not consistently attend when needed; for example, 18 of 23 individuals who have a special diet (78%) had the dietitian/nutritionist present, and nine of 13 individuals who receive OT/PT services (69%) had the OT or PT present. A bar graph of overall facility attendance at "PSP's only," including attendance at part of the ISP meeting, for June 2013-Ocober 2013, showed a range of compliance from 79% (in July) to 94% (in October). Although overall attendance of required IDT members averaged greater than 80%, attendance (as noted above) was variable across team members. Because the need for attendance is determined at the ISP Preparation Meeting, the Monitoring Team presumes it is essential for the required IDT members to attend. While the Facility has little control	Noncompliance

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		over whether the LAR, family, and individual choose to attend, the professional staff who are needed must participate. The Monitoring Team reviewed the signature sheets and their notes from the meetings for the annual ISP meetings for Individuals #74 and #84 and for the Admission ISP meeting for Individual #28. Although the Monitoring Team did not review the list of required IDT members for the annual ISP meetings (and, of course, there could not be such a required list for the Admission ISP meeting), the following observations were made: • The signature sheet for the meeting for Individual #74 was incomplete. A physician was present but not signed in. At the Admission ISP meeting, family/LAR and psychiatrist were present but not signed in. • A physician was present for two of two annual ISP meetings (100%) but not at the Admission ISP meeting. • Individual #74 required a modified food texture and fluid consistency and avoidance of specific foods (anti-reflux diet); no dietitian/nutritionist was present. • The recently admitted individual (Individual #28) had diagnoses of esophageal reflux and anemia, and had tremors. No primary care physician was present. Refer to Provision L1 for additional concerns related to the need for participation by the medical provider for this individual. • Individual #28 had significant behavioral issues and was prescribed psychotropic polypharmacy and medication for extrapyramidal syndrome side effects; the psychiatrist was present and participated actively and addressed relevant clinical issues. It should be noted that the OT/PT and Speech-Language Assessments did not include one of the psychotropic medications in the list of psychotropic medications; this was not reconciled during the ISP meeting. However, the physical therapist at the meeting recommended referral to a neurologist due, in part, to the tremors; the individual's mother stated she believed the tremors began since the individual started some of these medications. The psychiatrist addressed movement disorders. • Direct Support Staff were present at three of three meetings (100%). • The individual was present at one of two annual ISP meetings (50%) and at the Admission ISP meeting. • Family/guardian (LAR) was present at three of three meetings (100%). The Monitoring Team reviewed attendance for two ISPs provided by the Facility, one for each living unit. For both ISPs reviewed, the IDT had designated the IDT members required to attend the ISP annual meeting as a part of the ISP Preparation Meeting. For the most part, the designated members did attend. In both cases, direct support	

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		professionals attended; in one of these ISPs, the IDT had identified the specific staff who knew the individual best and one of these staff did attend. The other ISP Preparation Meeting did not specify the direct support professionals as called for. In neither case did the IDT designate the Primary Care Provider (PCP) to attend, and in neither case was the PCP in attendance. A rationale for the PCP not being a necessary participant was provided for one of the two (50%). For Individual #143 for whom the rationale was provided, the ISP Preparation Meeting indicated the individual had no significant medical issues, but it was also noted in the Assessments Needed for the Annual ISP Meeting that the MD assessment was to clarify the diagnosis of cystoblastic anemia. For both individuals, the ISP Preparation Meeting indicated both the Contracted and Designated LA should attend, but the Designated LA did not attend either, including the ISP annual meeting for the individual who had an active referral at the time. The IDT chose to rescind the referral at the meeting, a decision that should have involved the Designated LA.	
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>Policy:</u> DADS Policy #004.1 defined "assessment" as "A formal document that identifies an individual's current level of functioning, preferences, strengths, needs, and recommendations to achieve his or her goals, promote independence, and overcome obstacles to community integration. The assessment is used to identify strengths and needs to support the individual in the development of training, participation, and service objectives listed in the "Action Plans" section of the ISP." For annual ISP planning meetings, the IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting, held approximately 90 days prior to the ISP meeting. The policy requires in Section III.C that these assessments be completed and placed in the share drive for IDT review no later than 10 working days before the annual ISP meeting to permit the entire interdisciplinary team (IDT) to review them. The assessments were to be used by the QIDP to develop an ISP Guide no later than five days prior to the ISP annual meeting. For a new admission, Facility policy requires that the assessments be completed and posted at least five working days prior to the initial ISP meeting. RGSC Standard Operating Procedure (SOP) ICF-IID 600-01 Individual Support Plan Process (August 2012) included the same requirements. <u>Extent to which assessments are conducted routinely:</u> Overall, improvement is still needed in completing routine assessments.	Noncompliance

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		Assessments for the ISP were still not routinely completed on a timely basis. In the current ISP procedure, the IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting. There was evidence the IDTs had begun making use of this function, as both (100%) recent ISPs clearly defined the assessments that were to be completed. Findings included: • In a sample of two recent ISPs reviewed, none (0%) had all assessments included and completed on a timely basis prior to the ISP annual meeting. • Overall for this sample of 23 assessments that were required to be completed 10 working days prior to the ISP date, 11 (48%) were completed on a timely basis. The Facility provided tables titled Assessment Report for each month from May 2013 through September 2013. The assessment reports listed all assessments down the side and, for each individual, gave the date the assessment was completed. The reports provided a percent of assessments completed timely. For ISP planning meetings held in June, July, August, and September 2013 respectively, the percent of assessments completed timely was 42%, 42%, 50%, and 46%. The reports also provided a percent of assessments completed by the date the report was developed in the following month; these were respectively 73%, 73%, 77%, and 75%. Because a new process of identifying required assessments at pre-ISP meetings had been implemented, these figures may have been lower than the actual percent of required assessments; some assessments that were not required may have been counted as not provided (and, therefore, not timely). These data on timely completion of assessments differed from the Key Indicators graph of percent of assessments completed. For the months of June, July, August, and September 2013, this graph and the table below it reported 82%, 86%, 85%, and 88% of assessments completed. The dates of review might have been different from the dates of review for the Assessment Reports. Still, it would be both more efficient and more useful for the Facility to have one set of accurate data to review to determine status. In any case, even these higher percentages indicate some need for improvement. The assessment report for new admissions also listed all assessments down the side and the dates assessments were completed for each individual. Admission assessments are due five working days before the ISP. Based on the ISP dates on the assessment report (and considering only clinical assessments needed in advance but not rights assessments, water safety assessments, and other assessments not typically done in advance of the ISP meeting), for the seven individuals listed, percent of assessments completed timely ranged from 16% to 36%. Considering assessments completed by the date of the admission ISP, the percent ranged from 46% to 89%. No individuals had an audiology assessment or dental assessment. Only three of the six individuals (50%) had a nursing assessment, no nursing assessments were timely, and one was completed more than a month following the admission ISP.	

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		For Individual #28, the Monitoring Team requested all assessments. The Monitoring Team reviewed the 2013 Assessment Report for new admissions and found that it listed assessments that had not been provided to the Monitoring Team, including the medical, vocational, and recreation assessments. Based on 19 clinical assessments listed on the Assessment Report (not including some forms and some assessments to be finalized based on information at the ISP meeting, such as the Preventative Care Flow Sheet and the Rights Assessment), seven of 19 (37%) assessments were posted at least five working days prior to the Admission ISP meeting, and 17 of 19 assessments (89%) were completed by the day of the ISP meeting. This does not provide time for the IDT members to review the assessments in advance of the planning meeting. There were specific examples of both improvement and need for improvement in providing routine assessments timely. • As reported in Provision P2, five of five 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 three years for all individuals. • As reported in Section R: o Four of four admitted individuals (100%) since the last review received a communication screening or assessment within 30 days of admission or readmission. o For nine of 13 individuals in Samples R.1, R.2, R.3, and R.4) (69%), 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. o Thirteen of 13 individuals in Samples R.1, R.2, R.3, and R.4 (100%) who were provided direct or indirect communication supports and services had an assessment or update current within the last 12 months. o For a sample of assessments selected by the Facility, the speech assessment continued to show improvement but still needed to do a better job in addressing identified communication difficulties as well as providing better guidance into how strategies and recommendations should be integrated into the daily schedule. • As reported in Provision M2, nursing assessments were not consistently completed timely. o One of one (100%) Admission Comprehensive Nursing Assessment was	

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		completed within 30 days of admission. o Zero of three (0%) Annual Comprehensive Nursing Assessments that were due were completed on time, according to Facility policy. o One of four (25%) Quarterly Comprehensive Nursing Assessments due were completed on time, according to Facility policy. <u>Extent to which assessments are conducted in response to significant changes in status:</u> Improvement has occurred but still is needed in completing assessments in response to changes in an individual's life. Examples of improvement include: • As reported in Provision L1, following an individual's return from hospitalization, the medical provider documented a post hospital assessment in a note. • Also reported in Provision L1 was comprehensive and clinically appropriate initial assessment of acute medical conditions. • As reported in Provisions L1, M1, and G1, a Morning Medical Report meeting provided a forum to discuss when an individual had a change of status and what actions needed to be taken. Examples in which improvement remains needed included: • 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, 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. Issues needing improvement included, among others: o Lack of documentation in the Integrated Progress Notes and other records made it difficult to determine when changes in health status initially occurred. o Lack of complete and appropriate nursing assessments in individuals' response to presenting signs and symptoms of changes in status; and/or changes in vital signs and oxygen saturation measurements, including consistent lung and/or bowel sound assessments for respiratory and gastrointestinal issues. o Lack of analysis of contributing problematic issues affecting acute changes in status. • As reported in Provision O2, the Physical and Nutritional Management Team (PNMT) carried out assessments for individuals referred. However, the date of referral was not provided, so it was not possible to determine whether assessments were initiated and completed timely. • Observation of the annual ISP planning meeting for Individual #84 raised a	

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		concern. The major concern identified was the failure to make a referral to PT regarding the fracture of the left humerus of 11/1/13. Since he was immobilized in a trough cast and sling, it was a concern that the PT stated he would be reassessed when the fracture healed. Without assessment and physical therapy he could suffer some impairment in range of motion. Further, the PT should to routinely assess the status of the cast. PTs should have more expertise than the nursing staff in making such assessments. Since he was independent in toileting prior to the fracture, the team should have discussed more the impact the impaired arm might have on his ability to get his pants down and up when using the toilet, as well as any need for additional supports for this function until his arm heals. In general, there appeared good participation by the IDT. The mother was well informed of her son's needs and contributed much to the discussion and decision making. • As reported in Provision L1, there were not consistent documented continued physical assessments by the medical provider through resolution of acute conditions. <u>Extent to which assessments are of sufficient quality to reliably identify the individual's strengths, preferences and needs/ assessments are conducted in response to significant changes</u> Quality and adequacy of assessments was variable across disciplines. • Provision J2 reported that psychiatric assessments were consistent with the requirements of Appendix B and were comprehensive. • As reported in Provision M2, review of comprehensiveness of nursing assessments found regression compared to the last compliance visit. Please refer to Provision M2 for specific information. • As reported in Provision K5, psychological assessments did not include a narrative summary of how results from assessments would facilitate the understanding of the individual's strengths and needs. • As reported in Provision O2, most elements that should be included in a Physical and Nutritional Management Team (PNMT) assessment were present in the sample reviewed. However, these did lack some important elements, such as review of oral hygiene status, of identified residual thresholds for individuals who are enterally nourished, and of current adaptive equipment. • Provision S1 reported that it was not clear from a review of individual records and program documentation that the findings of the FSA had been effectively used in the development of skill acquisition programs or that the FSA was revised as indicated by data from training. • As reported in Provision T1d and M3, improvement remains needed in the transition and discharge summaries.	

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F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	<u>Extent to which assessment results are used to develop ISPs:</u> Use of results from assessments to develop, implement, and revise ISPs was variable. There were positive examples of use of information from assessments in development of an ISP. • As reported in Provision M5, five of six (83%) Integrated Risk Review Form assessments provided clinical data that helped to develop plans to address risk. • As reported in Provision R2, Communication Dictionaries for five of five individuals (100%) were reviewed at least annually by the IDT as evidenced in the ISP and ISPAs. During the meetings, the IDT (including the DCP) discussed and revised the individual's communication dictionary as indicated. This offered an excellent example of integrated planning and discussion. • As reported in Provision P2 for a sample of nine ISPs or ISPAs reviewed, in seven (78%), skill acquisition programs or opportunities for skill acquisition that had been recommended in the OT/PT assessment were present. • As reported in Provision K5, the Facility continued to demonstrate skill in relation to environmentally based behavior when conducting Structural and Functional Assessments (SFAs). As reported in Provision K9, the information from SFAs, including potential functions of behavior, were included in PBSPs. As reported in Provision S1, in 10 of 10 records (100%), documents reflected that each individual had been provided with skill assessment by means of the Functional Skill Assessment (FSA). It was not clear from a review of individual records and program documentation that the findings of the FSA had been effectively used in the development of skill acquisition programs or that the FSA was revised as indicated by data from training. • Individual #145 was provided a SAP for hand washing. The SAP stated that the program was developed because of needs identified in the FSA. The FSA, however, indicated that the individual was independent in washing hands. • Individual #4 was provided a SAP for flossing her teeth. The SAP indicated that the FSA was used to assess flossing and that the assessment supported the need for the SAP. The FSA does not include an assessment of flossing ability. Furthermore, the FSA indicated the individual was independent in dental hygiene skills. Observations and record reviews also indicated other weaknesses relating to assessments and SAP development. • Two of two individuals (100%) had been assessed with a standardized adaptive skill rating scale in the past year. Neither of the ISPs and none of the reviewed	Noncompliance

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		SAPs integrated results from the standardized assessment. • Individual #4 was provided a SAP to teach her the purpose of hearing aids. The individual had been diagnosed with sensorineural hearing loss, a condition that limits the ability to hear high frequency sounds. The ISP indicated that the IDT believed the individual possessed functional hearing. Furthermore, the individual in the past had refused to wear hearing aids and indicated she could hear well. The IDT, however, approved the SAP to teach the purpose of hearing aids despite the lack of apparent need, the individual's indication that she preferred not to wear hearing aids, and the individual's indicated ability to associated hearing aids with hearing loss or difficulty. Several examples of concern were reported in Provision L1, • Observation of the Admission ISP for Individual #28 suggested that there were issues identified in assessments that should have been addressed in the ISP. The Individual was reported to have blood in his stool in the past, had low vitamin D level, and had an indeterminate hepatitis B result. These issues should have been addressed by the medical provider and a plan in place for the IDT to review. • At the annual ISP meeting Individual #74, the IDT met without having reviewed the number of seizures the individual had been having. The QIDP had to ask the nurse for that information, and the nurse stated she would get that information. The issue of the increase in seizures was raised by the individual's family; it was evident that this would not have been discussed in any detail had the family not made a point of it. Ultimately, after the family continued to raise the issue, the primary care physician recommended a referral back to the neurologist. However, there was no indication that any other actions would be taken to provide supports related to this individual's seizures; the new ISP was not provided to the Monitoring Team in time for it to be reviewed for this report. • At an ISPA meeting held for Individual #46, IDT members were unaware of recommendations made in a consultation report about the use of a C-PAP machine and several lifestyle recommendations to address severe sleep apnea. Also, a member of the IDT was proposing to have the individual sleep in the head-down position, which was contraindicated secondary to the Individual's known GERD and a specific recommendation by the medical consultant to ensure that the Individual slept with the head elevated at least 30 to 60 degrees. These examples provided evidence that the IDT members as a group were not familiar with either the diagnoses that would have been included in assessments or the recommendations from a consultation. As reported in Provision P2, for zero of nine individuals in Sample P.1 (0%), the	

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		ISP/ISPAs addressed each of the recommendations outlined in the current OT/PT assessment. Review of the two ISPs and supporting documentation provided by the Facility for Individuals #48 and #143 found the ISPs being developed did not include a full complement of individualized goals or objectives and/or strategies to address the array of supports and services the individual required. For example, for Individual #48, the Habilitation Therapies assessment indicated the individual would benefit from a "sensory diet" finding the best combination and timing of various sensory inputs: arousal levels, tactile defensiveness, fine motor weaknesses, and oral motor needs. The IDT did not develop a structured sensory diet approach for the individual. In addition, for Individual #143, the ISP stated the Nursing assessment indicated the individual was not a candidate for training in the area of self-administration. The SAMs assessment further indicated the individual could not reach for objects or hold a cup, but the ISP and Habilitation Therapies assessments indicated he could pick up objects as well as pick up and hold a Wonder-flo cup independently. A primary focus of the ISP was to build on the progress in this area of fine motor skills and tolerance for participation in such activities, as documented in the Habilitation Therapies assessment; four SAPs were developed to develop these skills. A SAMS objective to reach, for, pick up or hold his cup or some other related item would have been a very appropriate and integrated addition to this overall approach.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	<u>Adequacy of process to develop each ISP in accordance with ADA and Olmstead decision</u> In order for the State Office requirement to be met, each discipline's assessment needed to include an opinion/recommendation. In addition, at the ISP meeting, the IDT needed to make a recommendation to the individual/guardian. For the ISPs reviewed the Monitoring Team found the required determination was still not being consistently provided. • Of the two ISPs reviewed, for neither (0%) did all of the assessments include the applicable statement/recommendation. Of 23 total assessments reviewed, only five (22%) included a determination of whether the individual could be served in a more integrated setting. • Two of two ISPs (100%) included an independent recommendation from the professionals on the team to the individual and LAR that the individual could be served in a more integrated setting, but neither (0%) made a referral. • Of the two ISPs reviewed, neither (0%) adequately identified the protections, services and supports that would be needed by the individual in the most integrated setting. For the most part, a template statement indicated that the professional opinion was based on the current services and support being provided at the Facility and did not take into account that any different services	Noncompliance

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		might be needed in the community. • Of the two ISPs reviewed, neither (0%) evidenced proficiency in identification and addressing obstacles to living in a more integrated setting. The plans respectively identified LAR choice or individual choice as a barrier, but neither (0%) included an action plan to address/overcome obstacles identified that was adequate (i.e., individualized, measurable, and comprehensively addressed the obstacles). The Facility typically did not have an adequate basis for determining the preferences of individuals for living arrangements. Barriers to living in a more integrated setting did not always lead to goals, objectives, or service strategies. The ISP did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his/her needs. As described in Provision T1b2, IDTs did not develop individualized plans for education and awareness that would be sufficient to meet the learning needs of the individuals residing at the Facility. Evidence that assessments included the professional's determination of appropriateness of moving to a more integrated setting was found in other reviews of assessments. The Monitoring Team reviewed this for Occupational/Physical Therapy evaluations and Communication/Speech evaluations. All evaluations (100%) provided statements about appropriateness. Seven of 10 OT/PT evaluations (70%) provided a statement regarding "Factors for Community Placement" that is detailed and lays out the supportive services needed for successful living. The Monitoring Team observed annual ISP planning meetings for Individuals #74 and #84, and an Admission ISP meeting for Individual #28. There was discussion of movement to a more integrated setting at all three meetings. However, there was little discussion of obstacles or of goals or action plans that would address obstacles or increase likelihood of a successful move. • For Individual #84, there was discussion of community events the individual might like to go to, but there was no indication that goals for skill acquisition would be identified. • For Individual #74, whose LAR stated an interest in moving the individual closer to home, there was also discussion of activities. Involvement in community activities had been an action plan in the prior ISP. Review of a list of community activities engaged in by the individual indicated a high number of activities engaged in (a total of 84 in the prior year), but most of those were to a park or nature walk (52) or sports or soccer complex (11); one was to a restaurant, and four were to a museum or library. The Facility did not provide any evidence of	

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		skill acquisition training, nor was that discussed at the ISP planning meeting. When the topic of vocational training was discussed, the QIDP took the positive step of suggesting that job coaching or community employment would be something to explore, but there was no discussion of what kinds of jobs might be available if the individual were to move closer to home (or even whether community work would be a support to be provided), and, therefore, no indication that the selection of job training would be based on preparing the individual for a move. • For Individual #28, there was discussion of the goal of the individual moving home. There was not adequate discussion of how this would be affected by the individual's statements of possessing a firearm, the individual's known physical aggression, or the individual's unsubstantiated report of substance abuse, or of what supports and services should be provided in the ISP to address these issues. The discussion of moving to a more integrated setting at the point of initial planning following admission was a positive finding; the next step is identifying what issues must be addressed to make that more likely to occur.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	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	<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	Noncompliance

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	community participation;	integrated discussion." Furthermore, information from the PSI is to guide the IDT in identifying an optimistic vision of the preferred living environment. In the review of two ISPs selected by the Facility, the Monitoring Team found that neither (0%) had effectively incorporated individuals' preferences into related action plans. Overall, the Monitoring Team did observe some Action Plans related to preferences. • Only one of two ISP packets included a PSI; for the one that was available for review, for Individual #143, the analysis section was not completed, nor was information from it entered into the section of the ISP Preparation Meeting at which the form states, "Review, evaluate and revise the ***Preferences, Strengths and Tentative Goals*** identified in the Preferences and Strengths Inventory(.)" This section should be used to synthesize the various preferences and strengths identified and how these may be applied throughout the individual's life. As it was, the PSI offered only a listing of some preferences and strengths. The PSI reviewed also provided little information as to how these preferences and strengths were identified. For example, the PSI stated the individual liked the routine and structure of living at RGSC, but the only rationale for how this was known was that the individual had lived there for 39 years. Routine and structure were then listed in the ISP as important preferences, without any indication that these needs were limited to living options. In fact, a reading of the ISP suggested routine and structure were overarching needs. The narrative provided no indication as to how these needs might be addressed, other than his continuing to reside at the Facility. An analysis of the findings would have assisted the IDT to better understand the nature of his needs for routine and structure and appropriately integrate them in assessments and Action Plans. • The PSI for Individual #48, was not found in the documents provided by the Facility, so it was not possible to ascertain how effectively the strengths and preferences had been assessed and integrated into the ISP. There were brief lists of preferences and strengths in the PSI section of the ISP Preparation Meeting record. It was noted the ISP did integrate the individual's stated preference for hand held noisemakers (which was not listed in the ISP Preparation Meeting record) throughout the narrative of the ISP and did develop some Action Plans that could build on this preference to develop fine motor/grasping skills. This was a positive sign. <u>Extent to which ISP provides an explanation for any need or barrier that is not addressed</u> In neither of two ISPs (0%) were barriers to living in a more integrated setting adequately identified and addressed. Barriers to living in a more integrated setting did not always lead to goals, objectives, or service strategies. The ISP did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to	

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		identified barriers to living in the most integrated setting appropriate to his/her needs. As reported in Provision T1b1, the Monitoring Team found that obstacles to transition to the most integrated setting were not consistently appropriately identified or addressed. Neither of two (0%) recent ISPs reviewed evidenced proficiency in this regard. <u>Extent to which ISP encourages community participation</u> Neither of the two ISPs (0%) reviewed included specific skill acquisition action plans for implementation in the community, in which the objective provided a specific purpose and methodology, was couched in measurable terms, and defined a data collection and analysis process. As recommended in Provision T1b2, the Facility's IDTs should develop an individualized community participation strategy for each individual that takes in to account their specific learning needs, preferences, and strengths. 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.	
	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;	<u>Extent to which ISP specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference:</u> As reported in Provisions F1d, 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 For the two sample ISPs reviewed, it appeared the ISPs being developed did not include a full complement of individualized goals or objectives and/or strategies to address the array of supports and services the individual required. The IDTs did not consistently develop such a comprehensive complement of individualized goals and objectives that were relevant to and likely to lead toward attainment of outcomes related to each preference, meet identified needs, and overcome barriers to living in the most integrated setting. For example, for Individual #48 the Habilitation Therapies assessment indicated the individual would benefit from a "sensory diet" finding the best combination and timing of various sensory inputs: arousal levels, tactile defensiveness, fine motor weaknesses, and oral motor needs. This was highly recommended. The assessment indicated these activities would help the individual focus, enabling increased attention to non-preferred tasks. It was further noted these programs would need daily monitoring to maximize the effectiveness and provide appropriate education to staff, but that previous programs of this type had not been adequately monitored due	Noncompliance

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		to OT hours. The IDT did not develop a structured sensory diet approach for the individual, nor was there documentation of discussion or of an IDT decision not to implement this recommendation. ISPs reviewed did not clearly state observable and measurable goals and objectives. To find the goals, the Monitoring Team reviewed the ISPs, including Action Plans and Integrated Health Care Plans, as goals could be in any of these, as well as in PBSPs. Goals were not consistently stated in measurable ways. Measurable health care goals included specification of the desired weight range and that there would be no episodes of infections or skin impairments. Other than that, language of goals was nonspecific (such as, "Will provide an effective PNMP to decrease risk for choking/aspiration. Will maintain good oral hygiene."), and the actions for those goals did not include measures or criteria. Similarly, in the Action Plans, services and supports included, "Service OBJECTIVE" and "To wait for change after buying items." These were not defined well enough to be measurable. Presumably, the actual plans would have more clear definition of what is to be measured. It is important the IDT members are aware of the specific services to be provided and how progress will be measured. Furthermore, as noted in Provision F2a4, 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. Finally, there were examples in other sections of this report of a lack of individualization and/or measurable, observable goals. • As reported in Provision M3, zero of five (0%) Acute Care Plans had realistic, measurable, and/or observable outcome goals related to the acute problems. Zero of five (0%) Acute Care Plans were individualized sufficient to meeting the individuals' health care needs. All were copied stock care plans without adequate individualization. <u>Extent to which ISP encourages community participation:</u> One of the two ISPs (50%) reviewed included a specific skill acquisition action plan for implementation in the community. The SAP in question was not available to review to determine whether it provided a specific purpose and methodology consistent with assessed needs, was couched in measurable terms, and defined a data collection and analysis process, and the Action Plan and rationale in the ISP were minimal and nonspecific.	

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		As reported in Provision S3b, 60% of individuals had at least one SAP to be implemented in the community. This is a positive finding. The vast majority of these SAPs targeted use of money.	
	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, risk action plans, etc. A program to improve dining skills might include techniques to encourage eating at a reasonable pace for both social and risk prevention purposes; use of a graphic menu to assist the individual to identify preferences, learn the names of foods and make choices; incorporation of reinforcement for safe dining behaviors and/or replacement behaviors; and might describe both formal and informal opportunities for community dining. Overall, adequate integration should be demonstrated through: • Integration of various plans (e.g., PNMP, PBSP, counseling plans, psychiatric treatment plans, crisis intervention plans, integrated health care plans, etc.,) in a measurable way into the ISPs, through, for example, measurable objectives; • Individuals' personal goals, preferences and/or needs are integrated across and throughout Action Plans; • Delineation of various staff's responsibilities through measurable action steps (e.g., development of plans, ongoing monitoring, staff training, implementation, etc.) • Inclusion, as appropriate, of skill acquisition plans, services objectives, and other interventions, as necessary The Monitoring Team found some signs of improvement in integrating planning. • As reported in Provision O3, ten of 10 PNMPs (100%) 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. • As reported in Provision R3: o Communication Dictionaries for five of five individuals (100%) were reviewed at least annually by the IDT as evidenced in the ISP and ISPAs. During the meetings, the IDT (including the DCP) discussed and revised the individual's communication dictionary as indicated. This offered an	Noncompliance

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		excellent example of integrated planning and discussion. o Three of five ISPs reviewed (60%) 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. • At the annual ISP planning meeting for Individual #84, following discussion about use of communication book, the IDT discussed integrating use of the book as part of self-administration of medication program. • Section K and Section J discuss the collaborative work by the psychologists and psychiatrist to integrate the behavioral and psychiatric interventions for individuals with mental illness and behavioral concerns. Furthermore, communication strategies identified in communication assessments reviewed by the Monitoring Team were included in PBSPs for the individuals. However, as documented below, there were numerous examples in which ISPs did not provide evidence of integrated supports and services. For example: • Neither of the two (0%) plans reviewed for this section integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. For example, as described in Provision F2a2 above, the habilitation therapies assessment indicated the individual would greatly benefit from a sensory diet that would address, among other things, the individual's ability to focus and thus enable increased attention to non-preferred tasks. These outcomes would in turn have an impact on a number of the individual's needs in the areas of activities of daily living, behavior support and vocational skills, providing a valuable platform for integration. There was no evidence provided that would indicate the IDT determined that this approach should not be implemented. • 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 observed in the annual ISP planning meeting for Individual #74, the individual's father raised issue of increase in seizures. Staff discussed reduction done to an antiseizure medication but did not discuss more recent changes in medications that could affect seizures. Staff did not have at the meeting a record of the number of seizures and when they had occurred; therefore, they could not use this information to help plan further assessment or changes in medication or other services and supports. The IDT told the father to talk to the neurologist but did not establish any action plans to assist the father in doing this. After the father continued to raise the issue of increased seizures, the primary care physician recommended referral for a special appointment for the individual to	

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		have further review by the neurologist prior to the next scheduled appointment. • At the same meeting, the QIDP asked whether the individual had a skill acquisition plan (SAP) to eat more slowly. The speech pathologist did not know. IDT members need to be aware of programs and interventions so the range of supports to address a given concern can be integrated. • Furthermore, for Individual #74, several clinical issues were not listed on the draft ISP, or on the previous annual ISP, despite the clinical issues being well documented in the clinical record. For examples, the diagnosis of GERD, history of anal fistulectomy and sphrincterotomy were not on the previous annual ISP, or the current draft ISP. • The Monitoring Team observed the annual ISP planning meeting for Individual #84. In general, there appeared good participation by the IDT. Nevertheless, a major concern the Monitoring Team identified was the failure to make a referral to physical therapist (PT) regarding the fracture of the left humerus of 11/1/13. Since the individual was immobilized in a trough cast and sling, it was a concern that the PT stated he would be reassessed when the fracture healed. Without assessment and physical therapy the individual could suffer some impairment in range of motion. Further, the PT should routinely assess the status of the cast. Since the individual was independent in toileting prior to the fracture, the team should have discussed more the impact the impaired arm might have on his ability to get his pants down and up when using the toilet, as well as any need for additional supports for this function until his arm heals. • As reported in Provision M5, two of six (33%) IHCPs were sufficiently integrated among all relevant disciplines. • As reported in Provision O2, there was a lack of integration of the PNMT recommendations into the ISP and IHCP that included established thresholds for referral back to the PNMT. 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. • As reported in Section P, physical and occupational therapy services were not consistently integrated into the ISP. Thus, there was evidence of improvement in integrating services, supports, and treatment and care plans, but there were still opportunities that were missed.	
	4. Identifies the methods for implementation, time frames	<u>Adequacy of identification of time frames in action plans:</u> For neither of the two ISPs reviewed (0%) did action plans include adequate timeframes	Noncompliance

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	for completion, and the staff responsible;	for completion. Neither of the ISPs indicated timeframes for completion in the Action Plans. <u>Adequacy of identification of persons responsible in action plans:</u> Action Plans templates had columns headed "Persons Responsible for Implementation/Documentation," "Person Responsible for Plan Development," and "Person Responsible for Reviewing for Progress and Effectiveness & Frequency of Review." The ISPs typically indicated by position, rather than by person, who would be responsible for program planning, implementation, documentation and data review. The Action Plans for Individual #48 listed as "responsible person" "SLP, "DCP," and "QIDP." The Integrated Health Care Plan (which is part of the ISP), had columns headed "Person Responsible for Implementation" and "Person Responsible for Review of Progress & Efficacy"; these listed "HAB," Nurse," "PCP RN CM" (evidently meaning that both a primary care physician and nurse case manager would be responsible for review of progress and efficacy), "QDDP DCS HAB, " and similar listings by position. There was no indication of the actual specific staff who would be responsible. Furthermore, the only position listed on the Action Plans for review for progress and effectiveness was the QIDP. Although the QIDP has an essential role in carrying out monthly reviews, the QIDP does not have the clinical expertise to do all needed monitoring of progress. This did not yet appear to be sufficient to achieve the outcomes of ensuring program implementation was accomplished as required, however, as evidenced by findings in in Provision F2f which indicated that ISPs, including the completed Action Plans, were not consistently being put into place on a timely manner by those identified as responsible for ensuring plan development; and in Sections O, R, and S that reported lack of, or inaccurate, implementation of supports and services. <u>Methods for implementation:</u> 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.	
	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	To establish compliance in this provision, IDTs must develop individualized action plans that effectively address the individual's assessed needs for services and supports and to promote increased independent functioning both at the Facility and in the community, as well as design interventions, strategies and supports that can be practically implemented both at the Facility and in community settings. Neither of the two plans (0%) reviewed effectively addressed the individual's full array of needs for services and supports in a manner that was practical and functional across settings. • For Individual #143, the Speech assessment indicated the individual	Noncompliance

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		demonstrates negation when not wanting to transition between activities. This presented tremendous opportunities for developing functional use of current communication skills to indicate a preference regarding his schedule and further develop a cause and effect understanding. The Speech assessment also indicated staff should continue to challenge the individual with simple problem solving activities with his preferred activities, also an activity that could promote the understanding of a causal relationship between an action and a desired outcome. This would have wide applicability and functionality for the individual in most aspects of life and could certainly be designed as a SAP that would be eminently practical in implementation. No such SAPs were developed. • The ISP Preparation Meeting for Individual #48 indicated a SAP would be implemented to teach the individual to ask for seconds at mealtimes. According to the ISP narrative, this was not implemented due to time constraints. Given the apparent simplicity of the task and that it would naturally occur at mealtimes rather than requiring a separate activity, it would not appear that time constraints would factor into the actual practicality of implementing this objective. The ISP narrative further stated the SAP would not now be implemented because the individual's meal was being provided in half portions because he ate too fast, resulting in his leaving after the first portion was served, in turn preventing the staff from being able to gather sufficient data. As the individual had an assessed need in this area, it would seem the IDT could make adjustments to the program, such as prompting the request for seconds shortly before his first portion was gone, that would ensure its practicality rather than simply discarding it. It would also serve to ensure the individual had access to his whole meal. In terms of practicality, if the individual's pace of eating was too fast, it was unclear how dividing the portions would serve to slow the pace in any event. 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. Furthermore, sampled skill acquisition programs (SAPs) did not address specific needs from formal assessments, and they did not consistently target skills that would likely be useful for the individual. Similarly, the speech-language assessment for Individual #48 recommended against direct or indirect therapy or a SAP "as he appears to be at a functional level secondary to his age and diagnoses." Throughout assessments (such as the speech-language assessment), the structural and functional assessment, and the OT/PT assessment, the individual uses idiosyncratic phrases to indicate wants and needs; these provide opportunity to develop skills for more successful communication. Furthermore, the speech-language assessment included a recommendation for a SAP to	

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		ask for seconds at meals (which contradicts the recommendation in the same assessment not to have a SAP, and which would be a functional behavior), but there was no action plan for this, and the ISP did not document that this was a recommendation or that there was any discussion about it.	
	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 ISPs and Action Plans included in the ISPs did not identify the data to be taken or the frequency of data collection (Action Plans did list frequency of implementation, which was daily or weekly). Action Plans for Individuals #48 and #143 listed the "Data Sheet/Documentation Form," which was always "Progress Note," but not the actual data to be collected and monitored for progress. The IHCP for Individual #48 (no IHCP was provided for Individual #143) did not list clinical indicators of the specific health conditions being addressed but did, in goals, state, "No episodes of infections or skin impairments" (which implies data on infections and skin impairments), "decrease episodes of aggression and destructive behavior" (which were defined in the PBSP), and "maintain recommended weight range" (which implied the individual would be weighed periodically). Although there was a service objective for "staff to brush the individual's teeth after he does own training," there was no measure of oral hygiene status and, as noted above regarding SAPs, no statement in the Action Plan of how progress on toothbrushing training would be measured other than "Progress Note." <u>Extent to which ISP identifies the person(s) responsible for the data collection, and the person(s) responsible for the data review:</u> For two of the two ISPs reviewed (100%), the Action Plans defined the person(s) responsible for data collection by position (for Individual #48, one of these was "SLP" and the others were DCP" and all for Individual #143 were "PNA"-the position title at RGSC for a DCP). Similarly, for two of the two ISPs reviewed (100%), the Action Plans also defined the person(s) responsible for data review by position. This did not appear to be sufficient to achieve the outcomes of ensuring program review was accomplished as required, however, as evidenced by the findings described in Provision F2d below.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	<u>Adequacy of coordination of goals, objectives, anticipated outcomes, services, supports, and treatments 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 Facility continued to implement initiatives toward coordination among staff, such as improved collaboration on the development of PBSPs among psychologists, speech clinicians, and psychiatrists. However, there were instances that indicated a lack of coordination of goals, objectives,	Noncompliance

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		and treatments. • As reported in Provision R3, zero of five ISPs reviewed (0%) included how communication interventions were to be integrated into the individual's daily routine. Three of five ISPs reviewed (60%) 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. • Provision M3 reports that acute care plans were not integrated with other relevant disciplines. The ISPs reviewed for Individuals #48 and #143 gave little indication in the ISP or Action Plans of integration of services. One plan that had an indication of integration was the handwashing SAP for Individual #48; this activity of daily living was to be trained at a naturally appropriate time, as part of the Self-Administration of Medication program during medication administration. Also, the ISP stated the individual "requires pre-sedation prior to medical and dental appointments"; there was no program to minimize need for pre-treatment sedation listed in the Action Plan, but there was a statement in the IHCP that the individual already participates in dental rehearsal. No other action plans showed evidence of coordination either across goals or across responsible disciplines that might be able to offer expertise to improve the effectiveness of the programs. The Monitoring Team would welcome documentation of such coordination at future compliance visits.	
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	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> 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., DCP/PNA could include any and all direct care staff) could make it difficult for specific staff to know	Noncompliance

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		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. It was unclear in some cases whether lack of implementation of supports and services was due to a lack of inclusion or clarity in the ISPs or of lack of comprehension by the staff responsible for implementation. For example: • The Monitoring Team did not observe use of general use alternative and augmentative communication devices that were present in residential and vocational areas. 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. • 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. It should be noted that positioning and transfer plans were implemented as written, a positive finding. • Although active engagement had improved across environments, there remained environments in which little active engagement occurred. The Monitoring Team did not do an extensive review of ISPs to determine which had Action Plans for activities to promote during unstructured periods, so it is not possible to state whether this resulted from a lack of guidance in the ISPs or from lack of comprehension of what the ISP required. In either case, there are many opportunities during unstructured times for individuals to engage in learning that may support goals in the ISPs, but these were not consistently occurring. Furthermore, staff interviews indicated a lack of knowledge of programs. For example, only one-third of a sample of staff asked questions about the communication-related programs of individuals were able to answer accurately. It will be important for the Facility to ensure not only that ISPs are physically accessible, but also that they are comprehensible, and that staff are familiar with the essential information about individuals that are found in the ISPs.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two	<u>Monthly review of progress</u>: The Facility required the QIDP to make an overall monthly review and evaluation of progress. The Facility also required quarterly reviews by the IDT and using the ISPA	Noncompliance

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	years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	process. The ISP Preparation (Pre-ISP) meeting also provided an additional process to alert the IDT to a lack of progress and/or significant changes that had occurred during the year. This preparatory activity should complement the monthly and quarterly review processes and ongoing IDT discussions that should be occurring. Although the documentation for two sampled individuals documented monthly QIDP reviews, the IDTs did not consistently ensure assessment of progress on a monthly basis, or more frequently as needed, or make revisions if there was a lack of expected progress. Examples included: • For one of two ISPs (50%) completed prior to the monitoring visit, there was evidence the QIDP had made a timely monthly review over the past three months. • The monthly reviews provided for Individual #143, evidenced little actual progress evaluation or program modification. For July 2013, the review of action plans indicated only to "continue until new SAPs were implemented," presumably referring to the upcoming ISP to be held in August. The August and September reviews indicated only to "continue new programs implemented at annual staffing" or that the program had been deleted. • As documented in Provision P2, for individuals with PNMPs or SAPs focused on indirect services, for zero of nine individuals from Sample P.1 (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. o The monthly QIDP review for this sample 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. • As reported in Provisions R3 and R4, individuals in the reviewed sample did not receive monthly and/or quarterly monitoring to ensure all communication supports remained effective and functional. Monthly reviews by the QIDP were either missing or simply stated to continue with no information provided regarding if the individual showed improvement or decline with their skills.	

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		o For one of three individuals (67%) progress notes occurred at a minimum monthly. o Quarterly documentation did not contain 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. There were examples in which the appropriate clinicians reviewed progress at least monthly. As reported in Provision K4 for a sample of individuals, data on behavior interventions are consistently reviewed monthly or more frequently as needed. However, as reported also in Provision K4, the data collection was not sufficient to assess progress. The Monitoring Team observed the quarterly review for Individual #79, and the Facility provided the ISPA. The QIDP led the meeting. IDT members present included the individual, a direct support professional (DSP) who worked with the individual regularly, a nurse case manager, psychology assistant, psychiatrist, and the Physical and Nutritional Management (PNM) nurse. There was extensive discussion of medical status, including a recent consultation and the need to ensure a follow up needed toward the end of the current quarter is documented and occurs. There was extensive discussion of an increase in vomiting and related changes in the tube feeding schedule, as well as a possible need to modify head-of-bed elevation. In addition, there was discussion of the need to reschedule replacement of the individuals feeding tube and to ensure tube feedings were occurring as required by the revised schedule. In discussing the use of psychotropic medications and the status of behaviors targeted for reduction, the participants reviewed data on the behaviors and discussed starting the use of a rating scale to provide information quarterly on target symptoms of diagnosed conditions (the DASH) and the findings from the first use of that tool. Overall, this quarterly review demonstrated excellent interdisciplinary discussion to determine whether there was any change in status that needed to be addressed and to follow up on current needs. The Facility might consider formalizing the review of status of action plans as a way to ensure that all action plans are addressed as needed. The Facility demonstrated significant improvement in conducting monthly reviews. To achieve compliance, the Facility should ensure monthly reviews by clinicians occur, monthly reviews by QIDPs include analysis of the information on progress and status,	

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		and continue to improve the quarterly review process to ensure progress on all action plans is reviewed and revisions in supports and services initiated as needed.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	<u>Competency-based Training on Development of ISPs</u> The Facility reported that all four QIDPs have completed competency based training. The Facility reported that there had been no change in the process for determining that the QIDP was competent at facilitation and at writing the ISP documents. The Facility used the Q Construction Facilitation curriculum for training in this area and for evaluating competence. The Facility reported all four QIDPs had been deemed competent. An annual competency recertification check had been done for the three QIDPs who had been at the Facility, and a new QIDP was certified as competent. The Self-Assessment reported that 96% of staff who were required to complete training in Supporting Visions, the ISP training package, had done so. During interview, the Monitoring Team asked for evidence staff receive competency-based training on implementation of plans for individuals for whom they are responsible, and updated training when plans are changed. The Facility reported that a process for requiring competency-based training on PBSPs, PNMPs, special considerations, and other services and supports was recently implemented. The Monitoring Team looks forward to seeing the progress of that process at the next compliance visit. The Facility should consider ways to ensure that pulled staff also receive competency-based training for individuals for whom they will be responsible. To ensure staff receive training as needed, the Facility needs to carry out monitoring of treatment integrity. That has not yet been fully implemented. • As reported in Section O, there was no process in place to ensure physical and nutritional management 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, it was limited to few staff. • As reported in Section K, reporting on graphs of the occurrence of treatment integrity checks had begun to occur. The Facility needs to ensure such checks are done regularly. The Facility has taken steps to ensure staff responsible for developing and implementing ISPs receive competency-based training. Implementation should continue and expand. Training of pulled staff will be important, as will processes to monitor implementation and determine when re-training is needed.	Noncompliance

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F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	<u>Extent to which ISPs are developed within 30 days of admission</u> Comparing a list of individuals admitted to the Facility and the dates of their ISP meetings from the 2013 Assessment Report, five of seven (71%) had an ISP meeting within 30 days of admission; the remaining two had an ISP meeting on the thirty-first day. DADS policy required admission assessments to be completed at least five working days prior to the Admission ISP planning meeting. Based on the ISP dates on the assessment report (and considering only clinical assessments needed in advance but not rights assessments, water safety assessments, and other assessments not typically done in advance of the ISP meeting), for the seven individuals listed, percent of assessments completed timely ranged from 16% to 36%. Considering assessments completed by the date of the admission ISP, the percent ranged from 46% to 89%. No individuals had an audiology assessment or dental assessment. Only three of the six individuals (50%) had a nursing assessment, no nursing assessments were timely, and one was completed more than a month following the admission ISP. Especially for individuals who are not well known to the IDT members, it is essential that assessments be completed timely so the participants in the planning process have the information they need to make decisions. <u>Extent to which ISPs are revised annually and as needed and put into effect within thirty days of preparation</u> According to a list of individuals, their dates of most recent ISP meeting, and dates of previous ISP meeting, all individuals who had resided at the Facility for more than one year had an ISP meeting annually, and all were held within 365 days following the prior ISP meeting. Assessments were not consistently completed 10 working days in advance of the annual ISP planning meeting. For ISP planning meetings held in June, July, August, and September 2013 respectively, the percent of assessments completed timely was 42%, 42%, 50%, and 46%. <u>Extent to which ISPs are put into effect within 30 days following preparation</u> The Facility provided a table from June11, 2013 through October 17 2013 showing ISP dates, the date the ISP was received and placed in the individual's record, and whether the ISP was received timely. Review of this table indicated that several ISPs were marked as received timely although they were actually recorded in the table as received 31 days following the ISP annual planning meeting. All told, of 30 ISP meetings listed on the table, 19 (63%) were filed within 30 days, and 23 (77%) were filed within 31 days. As reported in Provision K9 for PBSPs, implementation was routinely delayed, with an average delay between consent and implementation of 47 days. The Monitoring Team	Noncompliance

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		did not assess the length of time between completion of the ISP and implementation of other supports and services.	
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 ten monitoring tool audits of ISPs completed by the QDDP Coordinator, and ten completed by Quality Assurance Department staff; these were of the same individuals. These involved ratings of items on the Settlement Agreement Section F monitoring instrument. For each item on the instrument, a rating of 1, 2, or 3, or NA was provided. For each item rated (not NA), a score of up to 10 points was provided. The total score was added, and a percent of the possible score was calculated. The Monitoring Team did not request and was not provided definitions or guidelines for scoring. The QA staff rated one ISP 78%, one 97%, one 98%, one 99%, and the remaining six 100%. The QDDP Coordinator had exactly the same ratings for each individual. The Monitoring Team did not do an item by item review of agreement, since (except for one ISP), the monitoring indicated nearly perfect completion of requirements. However, these data were not consistent with the findings of this report. As reported above, based on both review by the Monitoring Team and on the Facility's own data, timeliness of assessments needed improvement. IDT evaluation of, and establishing actions to address, preferences, strengths, and needs also needed improvement. The Facility had only recently implemented a process to ensure competency-based training of staff responsible for ISP implementation, yet that was consistently rated "10." Thus, it was unclear that the monitoring process engaged in by the Facility accurately identified areas needing improvement and led to action.	Noncompliance

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 11/6/13 2. RGSC Action Plans 11/5/13 3. Presentation Book Section G 4. Provision Action Information for Section G 5. RGSC Standard Operating Procedure (SOP) ICF-IID 400 14; Medical Care, dated November 2004, revised October 2013 6. RGSC SOP 400-17 Consultation Request Process, 1/30/13 7. Change of Status (COS) Integrated Health Care Plan (IHCP) Form 10/30/13 8. RGSC Daily Morning Medical Report Meeting Record for 10/21/13, 10/22/13, 10/23/13, 10/24/13, 10/25/13, 11/18/13, 11/19/13, 11/20/13, and 11/21/13 and the first Monday of each month from April 2013 through October 2013 9. From Integration of Clinical Services committee meeting 11/20/13 a. Draft template for Individual Support Plan Addendum (ISPA) for pre-treatment sedation b. Individual Supports for Medical/Dental Appointment Form revised 7/26/13 c. Pre-Treatment Medical Sedation Discussion guide (undated) 10. Form AC 20 Referral/Consultation Report (Dictated Note) blank form 11. Form AC 20-MHRS/Consultation Report blank form 12. Monthly Consultation Audit blank form, to be completed by Nurse Case Managers **People Interviewed:** 1. David Moron, M.D., Clinical Director, and Lorraine Hinrichs, IID Program Director **Meeting Attended/Observations:** 1. Morning Medical Meeting 11/19/13, 11/20/13, and 11/21/13 2. ISP Annual Planning Meetings for Individuals #74 and #84 3. Integration of Clinical Services committee meeting 11/20/13
	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: ▪ Did not use monitoring/auditing tools. ▪ Used other relevant data sources and/or key indicators/outcome measures. Data included: o Attendance at ISP or ISPA meetings, percentage by various disciplines o Attendance at Incident Management Meeting o Attendance by core PNMT members at PNMT meetings o Percentage of scheduled consultations attended o Aspiration triggers/possible aspirations

	o Numbers of individuals diagnosed with aspiration pneumonia, bowel obstruction, constipation, and fractures, and number of falls o Percentage of diet orders recommended by the dietician receiving approval by the primary care physician (PCP) ▪ 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. However, many of the measures were outcome measures. The Facility provided narrative describing trends, analysis of some events, and either interventions that have contributed to outcomes or that a specific event was addressed. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ 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 ▪ The Facility data identified in the Self-Assessment some areas of need/improvement. However, it was unclear that the action plans specifically addressed those areas. For example, the Self-Assessment noted the need to improve attendance as ISP meetings and reported on the pre-IDT meeting process but did not include that in the Action Plan. Some areas were addressed. For example, the need for improvement in attending scheduled appointments was addressed through an action. ▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. Many actions were vague or addressed specific events rather than systemic improvements. For example, the action to address completing scheduled appointments was, "Monitor consultation schedule to ensure consults completed and develop action plans if necessary." This focused on addressing individual events; there was no description of systemic actions that might improve overall completion rates. On the same topic, an action that might address the issue systemically did not provide a clear sequence of actions; the action, "Ensure that IDT has ISPA meetings for all individuals who have refused or have difficulty completing consult appointments to discuss a range of pre-treatment sedation options and determine the most appropriate interventions" does not state how the Facility would ensure the meetings, how the range of pre-treatment sedation options would be developed, whether and how IDT members would be trained to determine the most appropriate options, and whether and how the process would be monitored to ensure it is occurring and that discussions are comprehensive. The Monitoring Team would also like to point out that such a process should discuss not only pre-treatment sedation options but also other interventions to minimize the need for pre-treatment sedation.

	Summary of Monitor's Assessment: The Facility had continued to progress toward providing clinical services in an integrated manner. 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 G1: The Morning Medical Report meeting and several integrated workgroups and committees had continued. Integrated discussion was observed at annual ISP planning meetings. The Morning Medical Report meeting needs to involve more interdisciplinary discussion; currently, it focused on reports of events and consultations. While these are useful for all disciplines to be aware of, they did not trigger identification of issues for which further discussion by this interdisciplinary group could be useful, either to provide suggestions for individual care or to identify systemic issues to address. There were examples of collaboration across disciplines, such as psychiatry with behavioral services, and speech and language involvement with positive behavior support programs; there were also examples in which collaboration was not occurring. Examples of IDT members lacking information needed for decision-making indicated a lack of integrated planning. Provision G2: The Facility had established policy and practices that address the requirements for Facility clinicians to review recommendations from consultants. Medical providers documented on the consultation report review of recommendations from non-Facility clinicians. Documentation did not consistently indicate that the Facility clinician agreed or disagreed with those recommendations, nor did they consistently complete integrated progress notes. The Facility had begun a monthly process of audit of consults and provided information on consults audited. Information was gathered by auditing a sample of consultations, using a standard audit form.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The Facility had continued to progress toward providing clinical services in an integrated manner. The Morning Medical Report meeting had continued, several workgroups and committees involved interdisciplinary participation, and integrated discussion was observed at annual ISP planning meetings. 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 clinical. Overall, adequate integration of clinical services should be demonstrated through: • Integration of various plans (e.g., PNMP, PBSP, counseling plans, psychiatric treatment plans, crisis intervention plans, and integrated health care plans) to address the same issue. For example, training in independent living skills might have components that include communication skills development, strategies for use of the skills in community settings, and incorporation of positive behavior support techniques. Treatment of a health condition might involve medical services,	Noncompliance

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		nutrition services, exercise and leisure activities, and behavioral services to increase compliance with health care, all aimed at the same goal of improving the diagnosed condition. • Information from assessments of various disciplines is integrated into and consistent across services or interventions so plans for treatments, supports, and intervention are consistent with that information. For example, prompts provided during skill acquisition training should take into account communication skills identified in communication assessments, sensory and physical movement issues identified in OT/PT assessments, and information from psychology assessments about intellectual function and adaptive behavior. <u>Policy</u> The Facility did not provide a policy that specifically addresses integration of clinical services. In response to a request for such policy, the Facility responded "Not available." However, the Monitoring Team noted that RGSC SOP 400 14 Medical Care does include some requirements for integrated planning, such as an expectation that the primary care physician (PCP) works with the RGSC Hospital Liaison during discharge planning from a hospitalization. The Monitoring Team suggests the Facility develop policy regarding expectations for integration of clinical planning, and to use that policy to guide development of processes to encourage implementation of the types of integration described above. <u>Integrated Care at Morning Medical Report Meetings</u> The Facility continued to hold Morning Medical Report meetings each weekday. The Facility had continued to conduct and to expand the integrated participation of staff attending the meetings. The purpose of the meeting is to discuss urgent clinical issues to ensure continuity of care, and to enhance clinical management of individuals. Disciplines participating in the meetings included: The Clinic RN who chaired the meeting, Medical Doctor, RN Case Managers, QIDP staff, Habilitation Therapy staff, QE Nurse, Speech Therapist, Psychology staff, Chief Nurse Executive, Nursing Operation Officer, Unit Nurse Manager or designee, Psychiatrist, CNE, NOO, QE Nurse, PNMT Nurse, Unit RN Case Managers, Clinic Nurse, QDDP Supervisor, Unit QDDPs, Speech Therapist, and Hospital Liaison Clerk who served as a scribe. There was a standard agenda for this meeting. Issues discussed included, but were not limited to: Medical on call report; hospital report; infirmary report; psychiatric; behavioral health related issues; pending medical consultations; wound care, and infectious disease issues; and significant medical conditions. There were also weekly topics. On Mondays the PNMT Director attended the meeting to report and discuss any cases of aspiration pneumonia and/or other related high risk conditions. On Tuesdays	

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		weekly consultations were reported and discussed. On Wednesdays nursing reported and discussed skin integrity issues. On Thursdays the Infection Control Preventionist reported and discussed infections. On Fridays consultation results were reported and discussed, along with in-services provided by the physicians and/or psychiatrist. Additionally, the meeting agendas typically covered the following items: • Items covered under old business: Continuation of previous day's business, approval of previous day minutes, pending or unfinished business. • 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. Review of the meeting minutes for the morning medical meetings that occurred from on the first Monday of each month, from April 2013, through October 2013 indicated very limited incidences reported by the living areas; there was no indication that specific staff members were assigned responsibility to follow-up on clinical issues reported, and specific follow-up dates were not listed. Review of minutes from 10/21/13-10/15/13 and 11/18/13-11/22/13 also found little evidence of discussion; most documentation involved reports of occurrences (such as that an individual had an injury or had not slept, or that an individual had been on a pre-transition visit to a provider), scheduled events such as consultations, or diagnosis updates. For the week of 10/21/13, two of five minutes included referrals/concerns from the IDT, one being a report that an individual had stayed a night at a group home, and the second reporting on an additional overnight visit to be done by the same individual, a reminder to report falls to HAB, and a report of IDT discussion that followed up on a dental visit (for more information on the last item, refer to Provision G2). During the week of the 11/18/13-11/22/13, three of five minutes included IDT concerns, but these were repetitions of the same concerns. The Monitoring Team attended the 11/19/13, 11/20/13, and 11/21/2013 meeting, and noted little interdisciplinary discussion. The meeting consisted mostly reading a list of clinical events that occurred on the day prior to the meeting and consultations that had been scheduled. At the meeting of 11/21/13, a QIDP reported on recommendations from a quarterly review for an individual an on a pre-ISP meeting for another individual; there was no discussion of the recommendations. Further, as noted in Provision M1, limited review of the Morning Medical Reports and Monitoring Team's attendance at the Morning Medical Report meetings did not find that actions for follow-up on relevant items were consistently included. As noted below	

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		regarding the Physical and Nutritional Management Team (PNMT), though, there was follow up on reports of change of status at the Morning Medical Report. It is possible that the minutes do not adequately report follow up that has occurred, or that such follow up is not reported at the meeting. The Morning Medical Report meeting needs to involve more interdisciplinary discussion; currently, it focused on reports of events and consultations. While these are useful for all disciplines to be aware of, they did not trigger identification of issues for which further discussion by this interdisciplinary group could be useful, either to provide suggestions for individual care or to identify systemic issues to address. The Facility might want to have staff visit other facilities to view how their morning report meetings are conducted, and how they document follow up actions and change of status. <u>Other Integrated Committees and Workgroups</u> The Physical and Nutritional Management Team (PNMT) was an interdisciplinary workgroup that met weekly. 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. However, as reported in Section O, there was a lack of integration of the PNMT recommendations into the ISP and IHCP that included established thresholds for referral back to the PNMT. The Facility reported that a wide range of staff attend Incident Management Review Team (IMRT) meetings, which provides an opportunity to discuss issues that may be revealed through review of incidents. As the parties agreed that the Monitoring Team would not review Section I of the Settlement Agreement, which reviews the IMRT, this report does not include any information about the topics, discussions, or actions taken as a result of IMRT meetings. The Facility holds Integration of Clinical Services meetings monthly to discuss processes and policies to increase integration. All clinical disciplines are involved in these meetings. At the meeting of 11/20/13, observed by the Monitoring Team, discussion was held on process for addressing missed consultations and for documentation and integrated discussion on pre-treatment sedation. This allowed various disciplines to review and participate in developing and revising these processes; this should help the Facility ensure that processes, as they are developed and revised, more comprehensively include actions by a range of disciplines that may address a particular need or goal. <u>Integrated Planning and Services</u> Numerous examples of integrated planning may be found throughout this report.	

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		• Section J reported improvements in collaboration between psychiatrists and behavioral services specialists. Both the psychiatrist and behavior specialist review each individual who is prescribed a psychotropic medication and collaborate in developing a treatment plan. • As reported in Provision P2, in seven of nine of the ISPs or ISPAs reviewed (78%), skill acquisition programs or opportunities for skill acquisition that had been recommended in the OT/PT assessment were present. • Communication Dictionaries for five of five individuals (100%) were reviewed at least annually by the IDT as evidenced in the ISP and ISPAs. During the meetings, the IDT discussed and revised the individual's communication dictionary as indicated. This offered an excellent example of integrated planning and discussion. • Positive Behavior Support Plans included communication strategies identified in communication/speech and language assessments and contained evidence of review by the speech and language pathologist. There were also examples of a lack of integrated planning. • For Individual #46, a lack of integrated planning was evident. This individual experienced a sudden episode of acute respiratory distress in the day room that was observed by the Monitoring Team's physician. Later in the afternoon an ISP Addendum (ISPA) meeting was conducted, which was a positive action. All relevant disciplines attended and discussed Individual #46's respiratory health history, current treatments, and recent consults with the pulmonologist and sleep studies, as well as for potential plans for managing his condition. It appeared to the Monitoring Team that the IDT was unaware of important medical diagnoses, and specific recommendations made by medical specialists. For example, the Individual had two sleep studies, one week apart, that demonstrated severe sleep apnea, and benefit by the use of C-PAP. The medical consultant made specific recommendations per two sleep study consultation reports. Initially during the IDT meeting the IDT members demonstrated no awareness that two sleep studies were previously completed, that the Individual benefited from C-PAP, and that there were specific medical recommendations for treatment, including life style changes, limiting caffeinated beverages, no sedating medications, sleep hygiene procedures, evaluation of certain laboratory studies, and to obtain a C-PAP device; the IDT members only became aware of this late in the meeting when the reports were reviewed. For more information, please refer to Provisions L1 and M1. • There was no effective process in place to ensure coordination between the neurologist and psychiatrist to coordinate the use of medications when they are prescribed to treat both seizures and a mental health disorder. • Three of five ISPs reviewed (60%) contained skill acquisition programs to promote functional communication. Strategies were not integrated into existing SAPs and	

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		SAPs were not developed to address identified concerns with communication. <u>Interdisciplinary Team (IDT) Attendance and Participation</u> For integrated planning to occur, clinicians must participate in interdisciplinary meetings, such as the ISP annual planning session. During the ISP Preparation meeting, the IDT was to identify the requisite composition of the team for the purposes of the annual planning meeting and record this in the Attendance-Assessment checklist. As reported in detail in Provision F1b, attendance was variable but had improved. The Facility tracked the attendance of IDT members at annual ISP meetings. The Self-assessment reported that 81% of required IDT members were present at the 29 ISP meetings held 5/1/13-9/30/13. The Self-Assessment included a breakdown by team members, including individuals, QIDPs, representatives from direct care, and various clinicians. Attendance of required team members ranged from 4% for physicians (the only discipline with attendance lower than 69%) to 100% with a QIDP present and the Placement Coordinator or Transition Specialist present, and a psychology assistant or behavior analyst was present at 100% of 27 ISP meetings for individuals receiving psychology services. The Facility provided a bar graph of overall facility attendance at "PSP's only," including attendance at part of the ISP meeting, for June 2013-Ocober 2013, that showed a range of compliance from 79% (in July) to 94% (in October). The Monitoring Team reviewed the signature sheets and their notes from the meetings for the annual ISP meetings for Individuals #74 and #84 and for the Admission ISP meeting for Individual #28. Although the Monitoring Team did not review the list of required IDT members for the annual ISP meetings (and, of course, there could not be such a required list for the Admission ISP meeting), based on review of the individual's status, most IDT members who were needed were present, but a nutritionist/dietitian needed for one individual, and a PCP needed for another individual were not present. The Monitoring Team reviewed attendance for two ISPs provided by the Facility, one for each living unit. For both ISPs reviewed, the IDT had designated the IDT members required to attend the ISP annual meeting as a part of the ISP Preparation Meeting. For the most part, the designated members did attend. Attendance alone does not provide a complete picture of the participation by IDT members in integrated planning. Through observation of meetings, the Monitoring Team can note whether the planning process involves integrative practices. Although in general there was good interaction across team members, some observations indicated a lack of integrated planning. • Observation of the annual ISP planning meeting for Individual #74 indicated the IDT did not have information needed about an increase in seizures. As reported	

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		in Provisions L1, F1d, and V4, the individual's father raised the concern; the nurse case manager stated she would need to look up the number of seizures the individual has had; this information is important for decision-making at the meeting and should have been provided to all IDT members.	
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.	Policy RGSC SOP 400-14 Medical Care requires that the PCP review recommendations from consultant physicians, that documentation of review be included in the medical record, and that a copy of the consult form be provided to the QDDP and reviewed by the IDT; the October 2013 revision states that the PCP or designee shares the consultation recommendations with the IDT, when applicable. 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 at the last compliance visit, 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	Noncompliance

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		to the Settlement Agreement-Program Improvement Committee monthly. This comprehensive policy covers the major issues of consultation. <u>Review of Consultations by Facility Clinicians</u> The Monitoring Team reviewed a sample of 18 consultation reports for 14 individuals (Individuals #4, #5, #8, #11, #29, #31, #40, #55, #65, #67, #81, #85, #91, and #150). Fourteen reports were for medical consultations, and four were for modified barium swallow studies (MBSS). For 17 of the 18 consultations (94%), documentation of primary care physician (PCP) review was provided on the consultation report. For eight consultations (44%), the PCP had documented in an integrated progress notes within five days of the report. Thirteen reports (72%) included documentation that the PCP agreed with the recommendations. No reports had documentation that the PCP disagreed. Five reports (28%) did not have documentation of agreement or disagreement. An additional issue involved dentistry. The Facility did not employ a dentist, and dental services were provided by appointment with community dentists. The Monitoring Team reviewed all dental consultations reports and dental progress notes completed by the community dentist for nine individuals from July 29 2013 through November 4 2013; three individuals received multiple consultation reports during the period from May 2013 to November 2013, so the total number of consultations was 14. Fourteen of 14 consultation reports (100%) had documentation of review by the Facility physician within five days of the consultation. For twelve of 14 (86%), the consultation report form was provided; in all cases, the physician agreed with the dentist's recommendation. No reports (0%) documented evidence 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 Report meeting. For most consultations, the meeting record simply reported the consultations to be done that day and each that had been scheduled, if it occurred and the recommendations, if it did not occur and the reason, or that the individual was uncooperative and a plan to reschedule. When the IDT became involved, the meeting record reported what was done. For the nine meeting records reviewed, there was one example; in the meeting record for 10/24/13, the meeting record indicated that the dentist recommended for Individual #11 "pre-sedation for next visit." The IDT, however, recommended scheduling the next appointment shortly after the individual's afternoon medication. This verified that the IDT review was substantive and produced a recommendation to provide an alternative support that was integrated with an existing support.	

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		Nonetheless, another example indicated that the information from consultant recommendations either does not always reach the IDT or that IDT members do not always consider the information. At an ISPA meeting held for Individual #46, IDT members were unaware of recommendations made in a consultation report about the use of a C-PAP machine and several lifestyle recommendations to address severe sleep apnea. <u>Processes for Review and Audit of Consultations</u> The Morning Medical Report agenda lists a weekly presentation of data on consultations on Tuesday. Minutes for the Tuesday meetings of 10/22/13 and 11/19/13 documented summary data about consultations for the prior week. The Facility reported that Nurse Case Managers audit consultations monthly and provided a blank audit form that included the case number, date of physician's order, date consult is scheduled, date consult is completed, date the consult report is received, date the physician reviewed finding, and comments. This is intended to provide an ongoing check to ensure consultations ordered are completed and reviewed. <u>Summary</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 but did not consistently complete integrated progress notes. Reporting at the Morning Medical Report meeting provided opportunity to discuss recommendations; documentation mostly consisted of lists of consultations and should reflect also any discussion of recommendations or concerns. To achieve substantial compliance, the Facility should consider developing a process to monitor whether the PCP documents in integrated progress notes. It would also be useful to determine the comprehensiveness of those notes and whether the IDT reviews recommendations as needed.	

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 11/6/13 2. RGSC Action Plans 11/5/13 3. Presentation Book Section H 4. Provision Action Information for Section H 5. Change of Status (COS) Integrated Health Care Plan (IHCP) Form 10/30/13 6. DADS Policy 004.1 Individual Support Plan Process and attachments (11/20/12) 7. DADS Policy 009.2 Medical Care 5/15/13 8. RGSC Standard Operating Procedure (SOP) ICF-IID 600-01 Individual Support Plan Process (August 2012) 9. 2013 Assessment Report for newly admitted individuals from July 2013-November 2013 10. ISP Assessments Tracking Log May 2013-September 2013 11. Meeting records for Settlement Agreement-Program Improvement Council (SA-PIC) meetings of 10/3/13 and 10/24/13 **People Interviewed:** 1. David Moron, M.D., Clinical Director, and Lorraine Hinrichs, IID Program Director **Meeting Attended/Observations:** 1. Morning Medical Report Meetings 11/19/13, 11/20/13, and 11/21/13 2. ISP Annual Planning Meetings for Individuals #74 and #84 3. Meetings attended by Monitoring Team members noted in several report Sections
	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 tools the Facility used to conduct its self-assessment included: ▪ Internal Medical Provider Audit for Round 7 ▪ Section I At-Risk monitoring tool o It was unclear whether monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility identified specific indicators for Provision H1 but not for Provision H3, where it is also listed as part of the information reviewed. For the Section I monitoring tool, the Facility did not indicate what specific items were relevant to, and considered in assessment of, status of

	compliance in Section H; only an overall percentage was provided. o The following staff/positions were responsible for completing the audit tools: The Self-Assessment did not identify who completed the internal medical audit. ▪ Used other relevant data sources and/or key indicators/outcome. Data included: o Timeliness of assessments o Numbers of individuals diagnosed with several medical conditions (stated as "to determine if IDT is providing proper integrated plans to minimize identified risks.") o Numbers of medication variances o Data by home and quarter of "% Out of Parameters" and underweight/overweight o A1c data o Completion rates for MOSES and DISCUS side effects scales ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Did present many findings consistently based on specific, measurable indicators o Did not 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 being in compliance with the following provisions of Section H: Provision H5. This was not consistent with the Monitoring Team's finding. The Monitoring Team found the Facility in compliance with no provision of Section H. Assessments were not yet completed timely. The Facility did not have a process to track clinical indicators of health status, including status of individuals with chronic conditions. 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. There was not a clear connection between specific areas of need/improvement identified in the Self-Assessment and the actions listed. ▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. For the most part, the actions involved continuing audits and monitoring, and meeting with or informing staff of status, or flagging emerging issues. There were no plans for sequential action steps to address gaps between current status and compliant status.
	Summary of Monitor's Assessment: Progress toward compliance with the requirements of this Section was limited. Some improvements were noted, but other areas showed little progress. The parties agreed that Provision H2 would not be monitored at this visit. Improvement is needed in completing routine assessments on a timely basis and in response to a change in an individual's status. Quality and comprehensiveness of assessments varied across disciplines. The Facility did not have procedures in place to ensure or monitor that treatments and interventions were

	implemented timely. Most treatments and interventions were implemented timely, but several provisions of this report provide examples in which treatments and interventions were not provided timely. The Facility did not provide evidence of expansion of the identification and use of clinical indicators, either for monitoring health status and assessing effectiveness of treatments and interventions for individuals or for assessing system-wide status of health care.

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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>Policy</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 and no later than five days prior to the initial admission ISP. RGSC Standard Operating Procedure (SOP) ICF-IID 600-01 Individual Support Plan Process (August 2012) included the same requirements. <u>Extent to which assessments are conducted routinely</u> Overall, improvement is still needed in completing routine assessments. Assessments for the ISP were still not routinely completed on a timely basis. The Facility's Self-Assessment for this provision provided a tracking spreadsheet during 4/1/13 through 9/30/13 that documented that 37% of required clinical assessments are posted to the share drive 10 working days prior to the ISP meeting. In the current ISP procedure, the IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting. There was evidence the IDTs had begun making use of this function, as both (100%) recent ISPs clearly defined the assessments that were to be completed. Findings included: • In a sample of two recent ISPs reviewed, none (0%) had all assessments included and completed on a timely basis prior to the ISP annual meeting. • Overall for this sample of 23 assessments that were required to be completed 10 working days prior to the ISP date, 11 (48%) were completed on a timely basis. The Facility provided tables titled Assessment Report for each month from May 2013 through September 2013. The assessment reports listed all assessments down the side and, for each individual, gave the date the assessment was completed. The reports provided a percent of assessments completed timely. For ISP planning meetings held in June, July, August, and September 2013 respectively, the percent of assessments completed timely was 42%, 42%, 50%, and 46%. These data on timely completion of assessments differed from the Key Indicators graph	Noncompliance

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		of percent of assessments completed. For the months of June, July, August, and September 2013, this graph and the table below it reported 82%, 86%, 85%, and 88% of assessments completed. These data would approach a level of compliance, but the Monitoring Team could not determine which data were accurate in reflecting timeliness. There were examples in which a specific discipline needed to improve timeliness. For example, six of 9 individuals' OT/PT assessments in Sample P.1 (67%) were dated as having been completed at least 10 days prior to the annual ISP. Completion of assessments following admission was variable across disciplines. Four of four individuals admitted since the last review (100%) received an OT/PT screening or assessment within 30 days of admission or readmission. Yet, based on the assessment report for new admissions, for the seven individuals listed, percent of assessments completed timely ranged from 16% to 36%. For Individual #28, the Monitoring Team requested all assessments. The Monitoring Team reviewed the 2013 Assessment Report for new admissions and found that it listed assessments that had not been provided to the Monitoring Team, including the medical, vocational, and recreation assessments. Based on 19 clinical assessments listed on the Assessment Report (not including some forms and some assessments to be finalized based on information at the ISP meeting, such as the Preventative Care Flow Sheet and the Rights Assessment), seven of 19 (37%) assessments were posted at least five working days prior to the Admission ISP meeting. <u>Extent to which assessments are conducted timely when there is a significant change of status for an individual</u> Improvement has occurred but still is needed in completing assessments in response to changes in an individual's life. Examples of improvement include: • As reported in Provision L1, following an individual's return from hospitalization, the medical provider documented a post hospital assessment in a note. • Also reported in Provision L1 was comprehensive and clinically appropriate initial assessment of acute medical conditions. • As reported in Provisions L1, M1, and G1, a Morning Medical Report meeting provided a forum to discuss when an individual had a change of status and what actions needed to be taken. • Four of four 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.	

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		Issues showing a need for improvement were evident. • As reported in Provision O2, the Monitoring Team was unable to determine if PNMT assessments/reviews for individuals in Sample O.2 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. <u>Comprehensiveness of Assessments</u> As reported in Provision F1c, quality and comprehensiveness of assessments varied across disciplines, with some (such as psychiatry and structural and functional assessments) being generally consistent with requirements, others (such as PNMT) having most but not all required components, and others (such as nursing) having regressed in quality. 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.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	The parties agreed the Monitoring team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	
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.	<u>Timeliness of treatments and interventions</u> 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. • As reported in Provision K7, RGSC experienced difficulty in implementing PBSPs promptly after approval and consent were obtained. For 40 of 49 active PBSPs (82%), there was a delay of greater than 14 days between consent and implementation. The average noted delay was 47 days. • As reported in Provision K4, for four of six PBSP progress notes (67%), modifications to the PBSP were supported by data as presented in the progress	Noncompliance

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		note data graphs. For the remaining two individuals in the sample, progress notes reflected that reviews of and changes to the PBSPs were not conducted when necessary. • As reported in Provision M5, our of six (67%) IHCPs indicated they were approved and implemented by the IDTs within 14 days. • As reported in Provision O3, for individuals in Samples O.1, O.2, and O.4 for whom the IDT identified changes needed to be made to the PNMP, ISPA meeting documentation noted for 13 of 25 individuals (52%) that the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. There were also examples in which timely implementation was evident. • For individuals receiving OT/PT supports and services, 10 of 10 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. <u>Clinical appropriateness of treatments and interventions</u> Examples were found of both appropriate treatment and treatment that could have been more assertive. • As reported in Provision L1, regarding cerebral palsy (CP): o There was a comprehensive plan documented on the annual medical assessment specific to the management of CP in zero out of four examples (0%). The plans documented were very basic and indicated to either continue current management, or "will get PT eval". All necessary monitoring parameters, necessary treatments, and consultations should be well documented as part of the clinical plan. o There was a well-documented assessment for spasticity on the annual medical assessment, as part of the physical examination, in zero out of four examples (0%). • As reported in Provision L1 regarding osteoporosis: o In zero out of five examples (0%) the annual medical summaries indicated a clinically appropriate action plan for osteoporosis. The clinical plan should include the specific recommended treatment, planned diagnostic follow-up, specific monitoring parameters for staff, and necessary supports and services. o Zero out of five examples (0%) included documentation indicating a clinical evaluation for the etiology of low bone density. It should be noted that the Facility provided a document that indicated that the etiology for underlying low bone mineral density was not evaluated. o Three out of five examples (60%) included evidence that a clinically appropriate diagnostic was obtained to assess bone density, and	

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		treatment efficacy, when clinically indicated. o Five out of five examples (100%) included evidence that a clinically appropriate pharmacological therapy was provided, as clinically necessary, to treat low bone density. • As reported in Section P, for zero of nine individuals in Sample P.1 (0%), the ISP/ISPAs addressed each of the recommendations outlined in the current OT/PT assessment.	
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 information on a few clinical indicators of efficacy of treatments and interventions for health issues but not on a broad enough range to address individual care and systemic review of the common and serious chronic health conditions found in the individuals served at the Facility. To determine whether clinical indicators were analyzed and reported for systemic quality improvement efforts, the Monitoring Team reviewed SA-PIC meeting records for October 2013; there was no evidence of review of clinical indicators of health status. Furthermore, Provision L4 reports that the clinical director informed the Monitoring Team that the Facility did not have a quality assurance process to assess clinical outcomes, but will be developing a process in the near future. All this was puzzling, as the Facility provided a short list of "additional indicators" at the last compliance visit. This was attached to the RGSC Quality Assurance Plan. At that time, the Clinical Director reported implementing tracking of episodes of possible aspirations and constipation. For further information, please review the report of the last compliance visit. The Monitoring Team had expected greater development of clinical indicators and would look forward to getting more information at the next visit. More puzzling was that the Self-Assessment included clinical indicators of system-wide status of healthcare, including number of episodes of possible aspiration, number of individuals with several health conditions, number of falls, number of individuals with different A1c levels, and number of individuals who are overweight or underweight. These are all clinical indicators that can be used for both assessment of system status and as part of a larger set of clinical indicators for assessing status of individuals and effectiveness of care. The Facility did provide data on use of benzodiazepines and antidepressants, but gave no indication of how these data are being used as clinical indicators of system-wide health status. The Facility also provided an agenda for the Medical Executive Committee meeting of 7/31/13. One item was monthly review of ICF-IID Clinical Indicators Report of May and June 2013, but the report was not attached for review.	Noncompliance

#	Provision	Assessment of Status	Compliance
		As reported in several sections, clinical indicators of efficacy of treatments and interventions were provided. • As reported in Provision K4, graphed data were consistently reviewed monthly or more frequently if needed. It should be noted that the data collection procedures permitted staff to wait until the end of shift to record data, which could have affected accuracy of the data. • As reported in Provision M1, five of six (83%) Integrated Risk Review Forms' (IRRFs') assessments provided clinical data that helped to develop plans to address risk. Two of six (33%) Integrated Health Care Plans (IHCPs) identified clinical indicators for all risk ratings to be monitored and the frequency for monitoring. • As reported in Provision O2, documentation for two of two individuals referred to the PNMT (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. • Provision R4 reported for three of three individuals' records (100%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. There were also instances in which clinical indicators were not provided. • As reported in Provision P2, for zero of nine individuals from Sample P.1 (0%), the ISP/ISPAs contained measurable objectives related to functional individual outcomes. Measurable outcomes were not consistently included as part of the ISP or ISPA • Provision Q2 reported that the Facility's ICF director, and the dental hygienist informed the Monitoring Team that it had yet to implement a dental QA process that assesses effectiveness of dental services and potential adverse outcome secondary to dental services. The requested documents were not provided by the Facility.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The Facility had not made progress on establishing a system to monitor the health status of individuals. As noted in Provision H4, the Facility did not provide information on tracking of clinical indicators, although the Self-Assessment provided data on a limited set of conditions. There was no indication that medical providers have tracked specified clinical indicators in monitoring individuals with chronic health conditions. The Morning Medical Report does provide a forum for an integrated group of clinicians to report and learn about changes in health status of individuals. Observation of meetings and review of meeting minutes indicated the meeting primarily involved	Noncompliance

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		reporting, with little discussion of whether the information indicated a change of status that needed to be addressed. There were problems in monitoring, documenting, and tracking health status, as the following examples show: • As reported in Provision L1, in reviewing examples of acute medical conditions, the Monitoring Team determined three examples required medical follow-up through resolution. Of the three examples, there was evidence indicating that one out of the three (33%) documented continued physical assessments by the medical provider through resolution. • As reported in Provision L1, the PT/OT assessment indicated specific measurements when assessing spasticity in zero out of four examples (0%). Appropriate clinical indicators of the individual's status could determine the measurements to be taken. • As reported in Provision O7 regarding assessing effectiveness of physical and nutritional management plans, zero of the 15 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 15 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. Zero of 15 individuals' records (0%) in Samples O.1 and O.2 included evidence that the team discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The Facility did not have clear guidance in policy or procedure on the use of clinical indicators or on when treatments and interventions should be modified. As noted in the last compliance report, RGSC had taken 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, no progress was reported since the last compliance visit in expanding the identification and use of clinical indicators as noted in Provision H4, and in developing clinical pathways. Given the lack of report of clinical indicators, it was difficult to determine whether treatments and interventions were modified in response to changes. Clearly, treatments	

#	Provision	Assessment of Status	Compliance
		and interventions were revised, especially in regard to acute health conditions. Nonetheless, there were examples in which changes did not consistently occur based on clinical indicators. • As reported in Provision K4, for four of six PBSP progress notes (67%), modifications to the PBSP were supported by data as presented in the progress note data graphs. For the remaining two individuals in the sample, progress notes reflected that reviews of and changes to the PBSPs were not conducted when necessary. However, one positive finding was that criteria for revision are now included in the PBSP. Further, progress was evident or the program was modified after three months for 67% of PBSPs reviewed.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The Facility policy governing common elements of clinical care was RGSC SOC ICF-MR 400-14. Although it includes information about integration of services, it did not provide extensive information about clinical policies and procedures. 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, DADS had not yet completed and implemented it.	Noncompliance

SECTION I: At-Risk Individuals			
#	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 parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
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 parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
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	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance

	shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.		

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Presentation Book, November 2013 2. RGSC Self-Assessment, 11/6/2013 3. RGSC Action Plan, 11/5/2013 4. DADS Policy 008.3 Behavioral Health Services Department Policy, dated 11/5/2013 5. Standard operating procedure, ICF-IID 400 16; Pre-treatment sedation, dated October 2013. 6. Curriculum vita and medical license for psychiatrists. 7. Annual psychiatric assessments, current positive behavioral support plan (PBSP) data, current psychotropic medication list, and most recent psychiatric evaluation, for Individuals #45, #94, #119, #79, #98, #123, #67, #77, #59, and #76 8. Schedule for combined psychiatry-psychology combined meeting to review behavioral and pharmacotherapies 9. The most recent psychiatric assessment, structural and functional behavior assessment a positive behavior support plan, annual psychology assessment, most recent ISP, current behavioral data, and current psychotropic medication list for Individuals #65, #55,#51, #139, #48, #33, #36, #140, #133, and #132 10. Monthly polypharmacy committee meeting minutes for June 2013 through November 2013 11. Data, graphs, and data analysis utilized by the polypharmacy committee, for the past six months 12. MOSES and DISCUS assessments for Individuals #59, #2, #15, #67, #97, #77, #79, #11, #55, #19, #127, #145, #108, #81, #46, #51, #60, #72, #36, #13, and #44 13. Memo by the clinical director indicating the rationale why Reiss screens were delayed, undated **People Interviewed:** 1. Dr. David Moron, MD (Clinical Director) 2. Dr. Rogers, MD (Chair, Polypharmacy Committee) **Meeting Attended/Observations:** 1. None
	Facility Self-Assessment: The Facility reported substantial compliance for Sections J.1 through J.3, J.5, J.6, and J.8 through J.11, and noncompliance with Sections J.4, J.7, and J.12 through J.15. The Monitoring Team concurred with the Facility's self determination of substantial compliance, with the exception of the following Sections: the Facility was in substantial compliance for Sections J.7 (which had a temporary failure to comply) and J.13, and was not in substantial compliance for Section J.10. The Facility utilized appropriate usage of relevant data that not only assessed completion of specific activities, but also the clinical relevance of the activity. For Section J.7, the Facility reported noncompliance because self-assessment data indicated that Reiss

	screens were not completed timely. The Monitoring Team noted this lapse in substantial compliance, and was informed by the clinical director that the Facility suffered a staffing issued that resulted in Reiss screens not being completed timely. The Monitoring Team considers this a temporary failure to comply within a period of otherwise sustained compliance and will continue to rate this as substantial compliance. The Facility must ensure that Reiss screens are completed within 14 days of admission to the Facility. The Facility's self assessment for Section J.13 indicated noncompliance. Following review of the data elements used for the self assessment, the Monitoring Team noted that the Facility indicated that it was in 100% compliance with tracked activities for this Section, and indicated within the self-rating component of the self assessment that "based on the result of this data, this provision is in compliance". The Monitoring Team concurs with substantial compliance for Section J.13. The self assessment indicated substantial compliance for Section J.10, and reported 94% of the audited quarterly psychotropic medication reviews indicated that the psychiatrist assessed risks of medication, diagnostics, and treatments, targeted behaviors, and polypharmacy, among other data elements. Unfortunately, the Monitoring Team was not provided with the requested documents as part of the on-site document review, and was unable to corroborate the Facility's self assessment. The Monitoring Team looks forward to reviewing this section for substantial compliance at future compliance visits.
	Summary of Monitor's Assessment: The Monitoring Team identified continued improvements, and movement towards substantial compliance with Provision J. The Facility had made significant enhancements in many sections, especially in areas such as assessing polypharmacy, integrating behavioral and pharmacological treatments, and by ensuring meaningful target symptoms for psychiatric conditions were identified and tracked. The Facility must continue to strive for improvements in several areas, such as improving the consent process for psychotropic medications, and ensuring that Reiss Screening assessments are completed on all new admissions, within two weeks of admission to the Facility. The following are specific comments for each Section: Section J.1: The Monitoring Team identified that the Facility had qualified professionals for the provision of psychiatric services, and therefore the concurred with the Facility's self assessment of substantial compliance for J1. The Monitoring Team recommends that psychiatrists be provided CME opportunities specific to ID/DD psychiatric practice. Section J.2: 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 concurred with the Facility's self assessment and determined that the Facility continues substantial compliance for Section J.2. Section J.3: There was no evidence to indicate that psychotropic medications were used as punishment; used in the absence of a valid DSM diagnosis; for the convenience of staff; or in place of a positive

	behavioral plan. In all cases there was a comprehensive assessment that included a behavioral-pharmacological hypothesis. For these reasons, the Monitoring Team determined that the Facility was in substantial compliance with Section J.3. Section J.4: The Facility updated its procedure for enabling and providing pre-treatment sedation for dental and medical indications. Although there were no examples of individuals being provided pre-treatment sedation, the Facility must have a functional mechanism process to help reduce the need for pre-treatment sedation, for instances when pre-treatment sedation may be needed. For this reason, the Facility remained in noncompliance with Section J.4. Section J.5: The Facility ensured that one full time equivalent locum psychiatrist was available to provide direct clinical care of the 50 individuals who were prescribed psychotropic medications. The Clinical Director provides approximately 25% time of direct clinical care, and oversees the clinical care provided by the locum psychiatrist. The Facility remained in substantial compliance with Section J.5. Section J.6: 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. Section J.7: The Monitoring Team will continue substantial compliance; however, the Facility must be in substantial compliance with Section J.7 at future compliance reviews. Section J.8: The Facility maintained a functional process that enables both the psychiatrist and BCBA an opportunity to review each individual who is prescribed a psychotropic medication and collaborate in developing a combined behavioral and pharmacological treatment plan. For this reason, the Monitoring Team determined that the Facility is in substantial compliance with Section J.8. Section J.9: The Monitoring Team was extremely impressed by the clinically appropriate and comprehensive structural and functional behavior assessment and positive behavior support plans; and that these plans are integrated into the IDT and ISP process. It was clear to the Monitoring Team that each plan reviewed was individualized and assessed pharmacological, behavioral, and other nonpharmacological interventions, with a goal to utilize the least restrictive intervention. For these reasons, the Monitoring Team determined substantial compliance for Section J.9. Section J.10: The Facility did not provide evidence to support that an IDT, which included the psychiatrist, psychologist, nurse and primary care physician, assessed the harmful effects of psychotropic medications, alternative treatments to psychotropic medications, or if the harmful effects of the mental illness outweigh the possible harmful effects of the psychotropic medication. Therefore the Monitoring Team determined noncompliance with Section J.10. Section J.11: The Monitoring Team was extremely impressed with the Facility's robust and effective

	polypharmacy committee process. Because the Facility assessed polypharmacy at both the system and individual level by ensuring appropriate diagnosis, targeted behaviors, and appropriateness of polypharmacy, and providing relevant recommendations to the prescribers of polypharmacy, the Monitoring Team determined that the Facility was in substantial compliance with Section J.11. Section J.12: Although the prescriber signed, dated, and completed the prescriber component of the side effects assessment tools, the Facility did not perform more frequent monitoring for emerging side effects secondary to a dose increase, or addition of a new neuroleptic. For this reason, the Facility is not in compliance with Section J.12. Section J.13: The Monitoring Team noted 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 reflected clinically appropriate targeted symptoms. For these reasons, the Monitoring team determined substantial compliance for Section J.13. Section J.14: 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 Section J.14, and encourages the Facility to develop a new consent process that will lead to substantial compliance. Section J.15: 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 Monitoring Team determined noncompliance for Section 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.

#	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 Section J1, the Monitoring Team reviewed the copies of the medical licenses, and C.Vs of the practicing psychiatrists. The Facility reported having two psychiatrists who provided coverage for psychiatry at the Facility: • Two out of two (100%) had current medical licenses. • One out of two (50%) was board certified in psychiatry, and one out of two (50%) was board eligible.. • Two out of two (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.	Substantial Compliance

		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.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. To assess compliance for Section 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, and than every second, for a total of ten individual on the list of all individuals who were currently prescribed a psychotropic medication (Individuals #45, #94, #119, #79, #98, #123, #67, #77, #59, and #76) • 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 Section 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	To assess compliance for Section 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 last ten individuals on a list of all individuals who were currently prescribed a psychotropic medication (Individuals #45, #94, #119, #79, #98, #123, #67, #77, #59, #76).	Substantial Compliance

	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.	Individuals prescribed psychotropic medication must have a nonpharmacological treatment program in order to avoid using psychotropic medication in lieu of a program. They must also have a psychiatric diagnosis, or there must be a specific behavioral pharmacological hypothesis, consistent with the use of the psychotropic medication. • The Facility provided annual psychiatric assessments for seven individuals, and quarterly psychotropic medication reviews for three individuals. Of the ten annual psychiatric assessments, and quarterly reviews, eight out of ten (80%) indicated an integration of behavioral data into the psychiatric assessment by the psychiatrist. Two individuals (#45, and #123) were recently admitted to the Facility, and data tracking was in progress. The Monitoring Team did note, however, that preliminary target symptoms were identified and listed on the quarterly psychotropic medication review form. • Ten out of ten psychiatric assessments or quarterly psychotropic medication review (100%) utilized DSM-IVR criteria when developing a psychiatric diagnosis. • In eight out of ten examples (80%) there was evidence to indicate that a bio-psycho-social hypothesis was developed, and assessed by the psychiatrist. For the two individuals who were recently admitted to the Facility, the bio-psycho-social assessment was in progress. Therefore, for eight out of eight (100%), bio-psycho-social hypotheses developed, the psychiatrist developed a clinically justifiable bio-psycho-social assessment when developing the treatment plan. • For each example reviewed, the psychiatric assessment documented a review of non-pharmacological interventions. <u>Medications Used for Punishment</u> 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, and quarterly psychotropic medication reviews that were assessed by the Monitoring Team. <u>Chemical Restraint</u> The Facility reported no usage of stat chemical restraint, therefore the Monitoring Team did not assess stat chemical restraint for this Section. It should be noted that the Self-Assessment for Provision N3 stated, "when an emergency chemical restraint for behaviors was needed, reviews for the events were conducted to ensure clinical appropriateness". In this case, the Monitoring Team was informed that there were no chemical restraints administered during the time frame that was assessed. The self-assessment for Section N.3 also indicated that "There were seven Chemical restraints from 04/2013 through 09/2013. Audit data supports the events were appropriately addressed and documented." This brings into question the data provided. The Facility will need to ensure data are accurate and consistent. For substantial compliance to be maintained at the next compliance visit, the Facility must ensure the Monitoring Team can assess whether chemical restraint was used as punishment.	

		Summary: There was no evidence to indicate that psychotropic medications were used as punishment; used in the absence of a valid DSM diagnosis; for the convenience of staff; or in place of a positive behavioral plan. In all cases there was a comprehensive assessment that included a behavioral-pharmacological hypothesis. For these reasons, the Monitoring Team determined that the Facility was in substantial compliance with Section J.3.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	To assess the Facility's ability to develop a process to help eliminate the need for pre-treatment sedation, the Monitoring Team requested 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 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 Program 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. Although the Facility provides a dental rehearsal program to help reduce the need for sedation during dental procedures, however, as per Section Q of this report upon review of datasheets for program implementation for the following individuals, the Monitoring Team noted that individuals were provided less then one program implementation each month: • Individual #66 was provided four dental rehearsals during the past six months • Individual #91 was provided one dental rehearsals during the past six months • Individual #36 was provided three dental rehearsals during the past six months • Individual #48 was provided 3 dental rehearsals during the past six months • Individual #51 was provided one dental rehearsal during the past six months 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. The Facility developed a standard operating procedure, ICF-IID 400 16, that was revised on October 2013, that delineates the Facility's process for enabling and providing pre-treatment sedation. • The Monitoring Team noted that the procedure did not comment specifically on clinical monitoring of the individual, and the need for close collaboration to ensure safety among various disciplines, including direct care support staff,	Noncompliance

		nursing services, and medical providers. • The policy commented specifically for an IDT to conduct a review for possible alternatives to the use of pre-treatment sedation, prior to the administration of a pre-treatment sedation; and also the need to document previous strategies that have been attempted in the past. The ICF-DD Director informed the Monitoring Team that the Facility did not administer pre-treatment sedation for dental, medical or other issues, during this reporting period. Summary: The Facility updated its procedure for enabling and providing pre-treatment sedation for dental and medical indications. Although there were no examples of individuals being provided pre-treatment sedation, the Facility must have a functional mechanism process to help reduce the need for pre-treatment sedation, for instances when pre-treatment sedation may be needed. For this reason, the Facility remained in noncompliance with Section J.4. The Facility should, however, enhance its procedure for pre-treatment sedation, and ensure that it delineates issues related to monitoring the individual during and after the administration of a pre-treatment sedative.	
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 Section J5, the Monitoring Team reviewed the copies of the medical licenses, and C.Vs of the practicing psychiatrists, and staffing ratios for practicing psychiatrists. In addition, the most recent annual psychiatric assessments were reviewed for Individuals #45, #94, #119, #79, #98, #123, #67, #77, #59, #76, #65, #55, #51, #139, #48, #33, #36, #140, #133, and #132. The Facility reported having two psychiatrists who provided coverage for psychiatry at the Facility: • One full-time board eligible locum psychiatrist, who provides direct psychiatric care. • One full-time board certified psychiatrist who serve as the clinical director, and provides direct psychiatric care approximately 25% time. • Two out of two (100%) had current medical licenses. • Two out of two (100%) demonstrated maintenance of CME credits; however, there was no evidence of CME specific to intellectual disability psychiatry. Review of 20 out of 20 (100%) annual psychiatric assessments indicated completion by a board eligible or board certified psychiatrist. Summary: The Facility ensured that one full time equivalent locum psychiatrist was available to provide direct clinical care of the 50 individuals who were prescribed psychotropic	Substantial Compliance

		medications. The Clinical Director provides approximately 25% time of direct clinical care, as oversees the clinical care provided by the locum psychiatrist. Given the Facility's current census of 65 individuals, and the 50 hours of hours of psychiatric services provided, the Facility remained in substantial compliance with Section J.5.	
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 #45, #94, #119, #79, #98, #123, #67, #77, #59, and #76) . • Eight out of eight psychiatric assessments (100%) adhered to Appendix B of the Settlement Agreement. Two additional examples were that of newly admitted individuals, and necessary data was continuing to be collected by the psychologist and psychiatrist. • 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. • Eight out of eight (100%) of the psychiatric assessments reviewed included a comprehensive review of appropriate behavior data. • Eight out of eight (100%) of the psychiatric assessments included a comprehensive mental status examination. • Eight out of eight (100%) of the psychiatric assessments include a justifiable psychiatric diagnosis, based on DSM-IVR criteria. The psychiatric assessments followed a standardized format and provided a comprehensive assessment of behavioral data, and specific signs and symptoms leading to an ICD diagnosis. The psychiatrist explored, and documented, a detailed bio-psycho-social assessment, that included exploration for alternative diagnosis. The standardized assessment format strictly adhered to the example found in Appendix B of this report. 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	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for three consecutive reviews. However, while on-site, the Monitoring Team was informed by the Facility's clinical	Substantial Compliance

	functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	director that during this reporting period, the Facility was unable to ensure that all new admissions were provided Reiss screens. The clinical director issued a memo, that was untitled and undated, to the Monitoring Team stating that the rationale for this lapse in compliance was secondary to a BCBA staffing shortage. Since hiring an addition BCBA, the Facility is now getting caught up with the lapsed Reiss screens. Summary: The Monitoring Team considers this a temporary failure to comply within a period of otherwise sustained compliance and will continue rating substantial compliance. The Facility must be in substantial compliance with Section J.7 at future compliance reviews in order to maintain this rating.	
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 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 (Individuals #45, #94, #119, #79, #98, #123, #67, #77, #59, and #76). 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 45, #94, #119, #79, #98, #123, #67, #77, #59, and #76, 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. • In ten out of ten examples (100%), there was evidence to support that the psychiatrist and BCBA worked collaboratively to ensure that both behavioral intervention plans, and pharmacological treatments were reviewed and concurred upon. • In ten out of ten examples (100%), targeted behaviors were documented, and there was documentation of clinically appropriate behavior intervention plans. The quality of these plans is discussed in Section K. • In ten out of ten psychiatric assessments reviewed (100%), there was specific evidence that clearly delineated a review of non-pharmacological interventions	Substantial Compliance

		to help mitigate maladaptive behaviors, and the need for psychotropic pharmacology. Non-pharmacological interventions included: programing interventions, behavioral interventions, environmental interventions, family involvement and family interventions, and medical interventions. • In ten out of ten examples (100%), the case formulation for the psychiatric assessment utilized data, and data analysis derived by the annual psychology assessment. • In ten out of ten examples (100%), psychiatric assessments were completed as a part of the IDT, which included the psychiatrist, nurse, psychologist, the direct care support staff, and the Q were documented to have attended the IDT. The clinical director informed the Monitoring Team that when necessary, the psychiatrist could have the medical provider join the IDT by phone. Summary: The Facility maintained a functional process that enables both the psychiatrist, and BCBA an opportunity to review each individual who is prescribed a psychotropic medication and collaborate in developing a combined behavioral and pharmacological treatment plan. For this reason, the Monitoring Team determined that the Facility is in substantial compliance with Section J.8.	
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	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 first, and then every second individual on the list of individuals prescribed psychotropic medications (Individuals #65, #55,#51, #139, #48, #33, #36, #140, #133, #132), copies of the most recent psychiatric assessment, structural and functional behavior assessment a positive behavior support plan, annual psychology assessment, most recent ISP, current behavioral data, and current psychotropic medication list. • The current psychiatric assessment documented clinically appropriate behavioral data that correlated with the DSM diagnosis in ten out of ten (100%) examples. • The structural and functional behavior assessment (SFA) and positive behavior support plan (PBSP), which is considered by the Facility to be an integral part of the ISP, and is reviewed and approved by the IDT demonstrated the following (for more detail, please refer to Provision K4): o Ten out of ten examples (100%) indicated a comprehensive and clinically appropriate behavioral hypothesis.	Substantial Compliance

	order to minimize the need for psychotropic medication to the degree possible.	o Ten out of ten examples (100%) documented clinically appropriate rationale for the current behavior and pharmacological treatment. o In ten out of ten examples (100%) the PBSP documented clinically appropriate target behaviors, that corroborated with targeted behaviors delineated on the psychiatric assessment. As reported in Provision K4, there was improvement noted regarding integration of assessments targeting behavior and mental illness, but there were examples in which behavioral indices of mental illness (that is, symptomatology to be tracked) were listed but without further discussion of the relationship between those and either the diagnosed mental illness or behavioral targets. o Ten out of ten (100%) examples indicated specific behavioral outcome data and objectives. o Ten out of ten (100% examples documented behavioral intervention strategies for staff to address behavioral exacerbations. o The SFA reports did not consistently describe differentiation between learned and biologically based behaviors. o Of the ten examples reviewed, nine included a RGSC psychiatric assessment. One example was a new admission to the Facility, and a complete psychiatric assessment was not completed, but the example did include a copy of the transferring Facility's psychiatric assessment. Review of the nine psychiatric assessments completed by the Facility, clearly delineated a careful review of non-pharmacological interventions in nine out of none examples (100%). For example the psychiatric assessment specifically addressed programing interventions, behavioral interventions, environmental interventions, family involvement and family interventions, and medical interventions. ▪ For Individual #55, the psychiatric assessment indicated targeted behaviors of biting self, and inappropriate sexual gestures, and commented on replacement behaviors for these targeted behaviors. For programing interventions, the assessment documented that a specific intervention was developed to help keep the individual in a stable environment, and indicated that this intervention is helping to reduce targeted behaviors. The assessment also documented specifics about medical interventions to help minimize the need for psychotropic medications, as seizure disorder may be contributing to maladaptive behaviors. The assessment also commented on issues related to disruptive family issues, and listed the Facility's strategy to enhance family relationship with the Individuals. ▪ The Monitoring Team also noted that the psychiatric	

		assessment indicated the various disciplines that participated at the psychiatric assessment IDT, when discussing the non-pharmacological interventions. In nine out of the nine examples (100%), the psychiatrist, psychologist, direct care support staff, the QIDP, and the nurse participated. There were also other examples, when PT/OT had participated. o The Facility conducts quarterly reviews that involve staff from several disciplines, where status is discussed and determination of continuing or revised treatment plans is done. Summary The Monitoring Team was extremely impressed by the clinically appropriate and comprehensive structural and functional behavior assessment and positive behavior support plans; and that these plans are integrated in the IDT and ISP process. It was clear to the Monitoring Team that each plan reviewed was individualized and assessed behavioral and pharmacological interventions, with a goal to utilize the least restrictive intervention. For these reasons, the Monitoring Team determined substantial compliance for Section J.9.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	To determine if the Facility conducted a comprehensive IDT review that included the psychiatrist, nurse, psychologist, and primary care physician, before initiating a new psychotropic medication, the Monitoring Team requested a list of individuals who were prescribed a new psychotropic medication during the reporting period; the most recent psychiatric medication evaluation, and copy of relevant ISPs for the last ten individuals on the list of individuals who were prescribed a new psychotropic medication. The Monitoring team was provided copies of medication orders; however, a comprehensive list of all Individuals who were prescribed a new psychotropic medication during the reporting period was not provided. Also, the Monitoring Team was not provided with ISPs, or related documents, for the last ten individuals who were prescribed a new psychotropic medication during the reporting period; therefore the Monitoring Team could not determine substantial compliance. Summary: The Facility did not provide evidence to support that an IDT, which included the psychiatrist, psychologist, nurse and primary care physician, assessed the harmful effects of psychotropic medications, alternative treatments to psychotropic medications, or if the harmful effects of the mental illness outweigh the possible harmful effects of the psychotropic medication. Therefore the Monitoring Team determined noncompliance with Section J.10.	Noncompliance
J11	Commencing within six months of	To determine if the Facility provided a mechanism that includes both systems and	Substantial

	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.	individual review of the use of polypharmacy at the Facility, the Monitoring Team met with the chairperson of the polypharmacy review committee, and requested that last six months of the polypharmacy committee minutes, including all data, graphs, and data analysis. Since initiating the polypharmacy committee in November 2012, the committee chairperson informed the Monitoring Team that all individuals who are prescribed psychotropic polypharmacy have been reviewed by the committee, and on-going reviews will ensure that all Individuals prescribed polypharmacy will be reviewed by the committee at least quarterly, and more frequently as clinically necessary. The polypharmacy committee meets monthly, and polypharmacy committee meeting minutes were provided for each month, 6/2013 through 11/2013. Review of the 11/19/2013 polypharmacy committee meeting minutes indicated that a total of 24 individuals were prescribed polypharmacy, which was an increase of four individuals noted from the previous month. The increase in Individuals was well explored and documented by the committee; the increase was attributed to the four new admissions to the Facility. The Committee meeting minutes indicated that five individuals were prescribed two psychotropic medications from the same class; eight individuals were prescribed three psychotropic medications; nine individuals were prescribed four psychotropic medications; two individuals were prescribed five psychotropic medications. The polypharmacy committee conducts a polypharmacy audit for individuals who are prescribed psychotropic polypharmacy. At the 11/19/2013 polypharmacy committee meeting, five individuals were reviewed by the committee (Individuals #36, #5, #46, #123, and #114). For each individual reviewed, the committee assessed appropriateness of the DSM diagnosis; MOSES and DISCUS assessments; drug levels and other relevant laboratory tests; and appropriateness of the prescribed polypharmacy. The following is a detailed overview of the polypharmacy committee's review of Individuals #36 and #114: • Individual #36: The polypharmacy committee indicated that the individual had a diagnosis of bipolar affective disorder type I, manic, moderate, and that the diagnosis was appropriate. At the 8/13/2013 polypharmacy committee meeting, the review of psychotropic medications noted that the individual was prescribed Haldol, Depakote, Lithium, Tegretol, and Thorazine. After reviewing laboratory data, and target behaviors, the polypharmacy committee raised concerns over elevated ammonia levels, and significant polypharmacy, and made recommendations for the prescriber to consider minimizing polypharmacy. The provider addressed the polypharmacy committee's recommendations and discontinued Haldol, Tegretol, and Depakote; hence, the Individual no longer met the criteria for polypharmacy. At the 11/19/2013 polypharmacy committee	Compliance

		meeting, the committee documented that despite no longer meeting criteria for polypharmacy, the polypharmacy committee will continue monitoring the Individual to assess efficacy of reduced polypharmacy. • Individual #114: At the 6/18/2013 polypharmacy committee meeting, the committee noted that the Individual had a DSM diagnosis of bipolar affective disorder, manic and that the diagnosis was appropriate. The Individual was prescribed risperidone, Zyprexa, Klonopin, and Depakote, and the committee requested the prescriber to provide clinical justification for the use of the polypharmacy, and to follow-up on noted abnormal labs. The committee also made specific recommendations for the prescriber to consider, to help reduce polypharmacy. At the 11/19/2013 polypharmacy committee meeting, the prescriber had provided the committee with a clinically rational plan to reduce polypharmacy, and there was evidence that the doses for Klonopin and Zyprexa were reduced. Review of the psychiatric polypharmacy audit forms for the remaining three individuals that were reviewed on 11/19/2013, indicated similar level of detail as the above two examples. In all examples the committee reviewed and assessed the psychiatric diagnosis, targeted behaviors, drug levels and other relevant labs, and appropriateness of polypharmacy. In all cases, there was evidence that the committee had requested specific justification for the use of polypharmacy, and when clinically appropriate issued specific recommendations to the prescriber to help reduce the use of polypharmacy.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	To assess the Facility's ability to ensure clinically appropriate drug monitoring of tardive dyskinesia, the Monitoring Team reviewed regularly scheduled MOSES and DISCUS assessments and assessments following changes in neuroleptic medications. The Monitoring Team reviewed a total of 26 MOSES and 18 DISCUS assessments provided for Individuals #59, #2, #15, #67, #97, #77, #79, #11, #55, #19, #127, #145, #108, #81, #46, #51, #60, #72, #36, #13, and #44: • In 26 out of 26 MOSES assessments (100%) there was evidence that the prescriber signed, dated, and completed the physician component of the assessment tool. • In 17 out of 18 DISCUS assessments (94%) there was evidence that the prescriber signed, dated, and completed the physician component of the assessment tool. The Monitoring Team requested all MOSES and DISCUS assessments completed for the first ten individuals, beginning in 5/1/2013, following either a dose increase of a prescribed neuroleptic, or if a new neuroleptic was initiated. The following is a summary of the Monitoring Team's review of the MOSES and DISCUS assessments provided for review. (The Facility provided only five of the ten examples requested, for Individuals	Noncompliance

		#60, #72, #36, #13, and #44): • More frequent monitoring for tardive dyskinesia was noted in one out of five examples (20%): o Individual #60: Only one, a baseline MOSES, was provided for review. There was no evidence of increased monitoring with MOSES and DISCUS. o Individuals #131, #44, and #72: Only MOSES assessments were provided, and in no case was there evidence of more frequent monitoring to assess for emergence of side effects secondary to an increase change of a neuroleptic. o Individual #36: There was increased monitoring with both MOSES and DISCUS assessment tools following dose increase of a neuroleptic. Conclusion: Although the prescriber signed, dated, and completed the prescriber component of the assessment tools, the Facility did not perform more frequent monitoring for emerging side effects secondary to a dose increase, or addition of a new neuroleptic. At the last compliance visit, the Monitoring team found that the Facility was completing this more frequent monitoring. For this reason, the Facility did not remain in compliance with Section N.5.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in	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.3, (Individuals #45, #94, #119, #79, #98, #123, #67, #77, #59, #76): • Of the ten examples, 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%) examples indicated that the psychiatrist at the quarterly psychiatric medication evaluation would assess therapeutic affects of medications. • Ten out of ten (100%) examples included incorporation of psychological, spiritual, biological, and environmental factors into the development of a diagnostic hypothesis, and treatment plan. • Eight out of ten (80%) structural and functional behavior assessment and positive behavior support plan had identifiable, and clinically relevant behavioral symptoms to monitor for diagnostic and treatment efficacy. As also stated in Section J.6, the psychiatric assessments followed a standardized format	Substantial Compliance

	the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	and provided a comprehensive assessment of behavioral data, and specific signs and symptoms leading to an ICD diagnosis. The psychiatrist explored, and documented, a detailed bio-psycho-social assessment, that included exploration for alternative diagnosis. The standardized assessment format strictly adhered to the example found in Appendix B of this report. Summary: The Monitoring Team noted 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; and that the structural and functional analyses reflected clinically appropriate targeted symptom. For these reasons, the Monitoring team determined substantial compliance for Section J.13.	
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 Monitoring Team began by interviewing the clinical director, who informed the Monitoring Team that it had not enhanced the consent process since the last Monitoring Team Review. Based on review of the Settlement Agreement, the Monitoring Team 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, the clinical director informed the Monitoring Team that it had not developed or implemented a new consent process, and the consent form did not include essential information, the Monitoring Team continued noncompliance for Section 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 Section 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 Section 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.	

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 – 11/6/2013 2. RGSC Action Plan – 11/5/2013 3. RGSC Presentation Book for Section K 4. Positive Behavior Support Committee meeting minutes – 04/06/2013 – 09/16/2013 5. Documents that were frequently reviewed included the annual ISP, ISP updates, Skill Acquisition Plans (SAPs), Positive Behavior Support Plans (PBSPs), structural and functional assessments (SFAs), structural and functional behavior assessments (SFBAs), 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 document reviews were conducted in the context of the Self-Assessment. 6. The review of data monitoring practices in K.4 included Individuals #5, #35, #45, #51, #55, and #84. 7. The review of Psychological Assessment reports in K.5 included Individuals #4 and #145. 8. The review of SFAs concerning assessment of behavior in K.5 included Individuals #4, #145, #48, #61, #123, #127, and #140. 9. The review of SFAs in the context of the integration of mental illness and behavior assessment in K.5 included Individuals #4, #145, #48, #61, #127, and #140. 10. The review of psychological testing, including adaptive skills and intelligence, in K.6 included Individuals #4, #145, #48, #61, #123, #127, and #140. 11. The review of psychological testing and evaluation reports for individuals admitted to the Facility since the previous site visit presented in K.7 included Individuals #6, #28, #45, #65, #119, #123, and #131. 12. The review of PBSPs in K.9 included Individuals #4, #48, #61, #123, #127, #140, and #145. 13. The review of data graphs in K.10 included Individuals #5, #35, #45, #51, #55, and #84. **People Interviewed:** 1. Ruben Nieto, BCBA – Behavior Services Director 2. Bernice Martinez, BCBA – Facility behavior analyst 3. Cheryl Fielding, PhD, BCBA – Contract behavior analyst 4. Megan Gianotti, M.Ed., BCBA – Contract behavior analyst 5. Approximately 15 direct care staff in both Facility residences as well as vocational and day treatment areas. **Meetings Attended/Observations:** 1. Positive Behavior Support Committee 2. Human Rights Committee 3. Observations were conducted in both Facility residences as well as vocational and day treatment areas.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section K. 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 K, in conducting its self-assessment, the Facility: ▪ Appeared to use monitoring tools, as the Self-Assessment included percentages of compliance. The Self-Assessment however, did not include a description of the monitoring tools or the methodology for conducting the assessment. ▪ Described reviewing such things as progress notes and staff implementation of PBSPs. The Self-Assessment did not provide specific information, however, about the tools used in developing this information. ▪ The Facility did not consistently present data in a meaningful or useful way. Specifically, the Facility's Self-Assessment: o Did not present findings consistently based on specific, measurable indicators. Although the Facility reported percentages for variables such Psychological Assessment reports with psychiatric information, the Facility did not describe what constituted sufficient quality to be rated as in compliance. Without adequate information about how such ratings were made, it at times was not possible to interpret the ratings or reach conclusions about compliance with the Settlement Agreement. o Did not measure the quality as well as presence of items. For example, ratings consistently focused upon whether a specific format was used or if specific items were in included in a report. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with the following provisions of Section K: Provisions K.1, K.2, K.11 and K.13. 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, In Process, and Not Started. ▪ The Facility data did not identify areas of need/improvement. ▪ The actions did provide a set of steps focused toward compliance with the requirements of this Section. The provided steps, however, emphasized quantitative rather than qualitative efforts, limiting their utility in achieving compliance with the requirements of Section K.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RGSC from 11/17/2013 through 11/22/2013. Record reviews continued off-site following the site visit. Based upon information gathered during the current site visit, it was apparent that the Facility had achieved substantial compliance with Provisions K.1, K.2, K.11, and K.13. Although several areas continued to lack substantial compliance, there were areas where notable progress had been achieved. • The Facility had improved the use of behavior intervention data. PBSP progress notes were updated and reviewed monthly, with the review conducted by a BCBA.

	• PBSPs included all required elements, and reflected sophisticated examples of behavior intervention methods. • A second BCBA had been hired by the Facility, allowing the Facility to meet requirements for staffing ratios and demonstrably competent staff. Despite the areas of improvement, the Facility continued to demonstrate limitations or a lack of progress in several areas. • Facility documentation did not reflect that all individuals with PBSPs were provided annual review by the Peer Review Committee. • PBSPs included instructions regarding data collection that permitted staff to delay recording data until the end of the shift, increasing the probability of data collection errors and potentially limiting the ability to develop sound treatment decisions. • Only 17% of people admitted to the Facility since the previous site visit had been provided with a Psychological Evaluation and testing within 30 days of admission. • The Facility did not consistently conduct assessments for data reliability or treatment integrity. Based upon the information obtained during the site visit, the Facility had continued to progress toward substantial compliance with the Settlement Agreement in relation to Section K. Although some areas continued to reflect considerable limitations, the efforts exhibited thus far by RGSC suggested that the Facility was acting in a deliberate and productive manner.

#	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. Viallarreal 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. During the May 2013 site visit, Ruben Nieto remained the only full-time, regular employee of RGSC who was a BCBA. <u>Current Site Visit</u> During the current site visit, Facility records regarding Behavior Services Department staff were reviewed. These records reflected that a second BCBA, Bernice Martinez, had been hired. This brought the total number of BCBAs at the Facility to two. As only two positions in the Behavior Services Department were eligible for board certification, it	Substantial Compliance

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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>was determined that 100% of the current Behavior Services Department staff possessed board certification.

<table><tr><td></td><td>Baseline</td><td>10/2012</td><td>7/2013</td></tr><tr><td>Percent of staff who were BCBAs</td><td>0%</td><td>50%</td><td>100%</td></tr><tr><td>Percent of staff lacking BCBA who were pursuing board certification</td><td>0%</td><td>0%</td><td>0%</td></tr><tr><td>Percent of staff who were BCBAs or were pursuing board certification</td><td>0%</td><td>0%</td><td>100%</td></tr></table>
Facility practice requires that all PBSPs were developed by a BCBA. To assess this practice, a sample of seven PBSPs (Individuals #4, #48, #61, #123, #127, #140, and #145) were reviewed. All PBSPs in the sample were developed by a BCBA.</td><td></td></tr>
<tr><td>K2</td><td>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.</td><td>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.</td><td>Substantial Compliance</td></tr>
<tr><td>K3</td><td>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.</td><td><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 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</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		contractual employee at RGSC. In August 2012, the Facility had only recently begun a revised internal and external peer review process. In May 2013, documentation supported a functional internal and external peer review process. <u>Current Site Visit</u> At the time of the current site visit, RGSC maintained a combined internal/external peer review process. The Peer Review Committee was comprised of four BCBAs (Ruben Nieto, Berenice Martinez, and consultants Dr. Cheryl Fielding, and Megan Gianotti), as well as the two Psychology Assistants (Michelle Melchor and Aurora Reyna). As noted below, one member of this committee served as an external consultant; therefore, this single process served as both internal and external review. The process for peer review consisted of the following steps: • The SFBA/PBSP was submitted to the internal BCBA reviewer. • The internal reviewer (Megan Gianotti) completed the evaluation tool and met with SFBA/PBSP author to review comments and suggestions. • The author revised the SFBA/PBSP as needed, with feedback from the internal reviewer, until a rating of 80% was achieved on the evaluation tool. • The internal reviewer forwarded the SFBA/PBSP, evaluation tool, and peer review response form to the Peer Review Committee scribe and external BCBA reviewer. • The Peer Review Committee scribe emailed the review materials to the committee members prior to the date of Peer Review Committee meeting. • The external reviewer (Dr. Cheryl Fielding) completed the evaluation tool for 25% of the SFBA/PBSPs submitted for internal peer review and forwarded the materials to the Peer Review Committee scribe prior to the committee meeting. • The Peer Review Committee reviewed the SFBA/PBSP and evaluation tools, and formulated the committee response. Peer Review Committee minutes reflected that between 4/6/2013 and 9/16/2013 (24 weeks), the committee met 14 times (58% of weeks). Based upon the Facility tracking spreadsheet, no intervention plans were completed and requiring review during those weeks that the committee did not meet. Therefore, it appeared that the committee met as frequently as was needed. Observations of a Peer Review Committee meeting were conducted on Monday, 11/18/2013. The meeting was well organized. The review of all materials was very thorough, including the minutes of the previous meeting. One intervention was presented (Individual #65). The presentation was comprehensive, and members offered substantive comments and suggestions. If all committee meeting were conducted in a	

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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>similar manner, and documentation suggested the current meeting reflected the norm, the process was more than adequate.

Documentation provided by the Facility reflected that 11 of 65 individuals with PBSPs (17%) had not had their PBSPs updated in over one year at the time of the site visit. As no peer review had been conducted since implementation, it was evident that not all individuals had PBSPs reviewed at least annually.

No individuals required a Crisis Plan, so no peer review of crisis plans was required.

Based upon the information and records available, it was evident the Facility had a peer review process in place. It was noted, however, that not all individuals with PBSPs received at least an annual review by the committee. It would be advisable for the Facility to develop a process whereby PBSPs dates were reviewed by the Peer Review Committee, with follow-up actions to ensure that no intervention plans lapsed.</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. In May 2013, documentation reflected substantial improvement by the Facility.

<u>Current Site Visit</u>
During the current site visit, the Monitoring Team selected a sample of six individuals for the review of data collection and treatment monitoring. This sample included individuals with recent ISPs, behavior assessments, behavior interventions, or psychotropic medication reviews. The specific individuals included in the sample were Individuals #5, #35, #45, #51, #55, and #84.

The table below reflects the results from the current site visit review regarding the collection and presentation of data.

<table>
<tr><td></td><td>3/2010</td><td>5/2013</td><td>11/2013</td></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress</td><td>0%</td><td>8%</td><td>0%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Replacement behavior data collection sufficient to assess progress	0%	75%	0%
Data reliability is assessed	0%	0%	33%
Target behaviors analyzed individually	0%	92%	100%
Targeted behaviors graphed sufficient for decision-making	0%	100%	83%
Replacement behaviors graphed sufficient for decision-making	0%	92%	83%

The greatest weakness noted involved data collection procedures for target and replacement behaviors. In both cases, staff was permitted to wait until the end of the shift to record target and replacement data. Allowing prolonged delay between observations and data recording was likely to lead to errors in recorded data.

The availability and presentation of treatment data is only one aspect of the process of monitoring the benefit of intervention plans and psychotropic medications. It is also necessary to conduct thorough reviews of the available data and to introduce changes in the treatment process when data indicate changes are necessary.

	3/2010	5/2013	11/2013
Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level	0%	67%	100%
Review is conducted by a BCBA	0%	0%	100%
Input from direct care staff is solicited and documented	0%	0%	100%
Modifications to the PBSP reflect data-based decisions	0%	50%	67%
Criteria for revision are included in the PBSP	0%	67%	100%
Progress evident, or program modified in timely manner (3 Months)	0%	33%	67%

The following factors were noted concerning the review of PBSP progress notes.

- Documentation provided by the Facility revealed that graphs of PBSP data were reviewed at least monthly.
- For every progress note in the sample, the monthly review was conducted by a BCBA.
- Every progress note reviewed included a narrative description of an interview with at least one staff member regarding changes in behavior. This narrative included specifics regarding the staff member interviewed and the behavior in

#	Provision	Assessment of Status	Compliance
		question. In four of six PBSP progress notes (67%), modifications to the PBSP were supported by data as presented in the progress note data graphs. For the remaining two individuals in the sample, progress notes reflected that reviews of and changes to the PBSPs were not conducted when necessary. • For Individual #5, progress notes reflected that physical aggression began increasing in May 2013, and by September 2013 had increased from one to seven displays per month. Although the progress notes made reference to the increase, no reviews of or modifications to the PBSP were documented since prior to the increase in behavior. • Progress notes for Individual #45 reflected that physical aggression had increased from two episodes per month in June 2013 to 17 episodes per month in September 2013. There were no indications in the progress notes that steps had been taken to ensure that the PBSP was appropriate for the behaviors being addressed. It should also be noted that despite treatment decisions appearing to follow the data in 67% of PBSPs, some of this might have been due to chance. It was reported by staff that the failure and revision criteria provided in the PBSPs were not consistently used when determining the need to revise an intervention. Rather, it was reported that decisions about revising PBSPs often were often made as part of the annual ISP process rather than the response by the behavior to the intervention. Based upon the documentation provided by the Facility, it was evident that progress had been made in meeting the requirements of Section K.4. At the time of the current site visit, however, further improvement was need in ensuring that data were collected and presented correctly, and that decisions concerning behavior interventions were evidence-based.	
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	<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 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. In May 2013, some regression was noted in the completion of psychological assessments and testing, as well as the presentation of testing results. <u>Current Site Visit</u>	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>that may require intervention.</td><td>During the current site visit, the Monitoring Team selected a sample of two individuals for the review of psychological assessment. This sample included individuals with recent ISPs, behavior assessments, or behavior interventions. The specific individuals included in the sample were Individuals #4 and #145.

<table>
<tr><th></th><th>3/2010</th><th>5/2013</th><th>11/2013</th></tr>
<tr><td>A Psychological Assessment had been completed.</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>The Psychological Assessment was less than one year old</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>The Psychological Assessment contained findings from an intellectual test administered within the previous five years.</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>The Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.</td><td>0%</td><td>100%</td><td>50%</td></tr>
</table>

Information obtained from the sample records, as well as interviews with staff, indicated that assessments of intelligence and adaptive skills were no longer conducted according to specific intervals. A review of the Facility tracking spreadsheet for psychological assessments revealed the following.
• Intelligence tests had been completed within the past five years for 64 of 65 individuals (98%).
• Testing of adaptive skills had been completed in under one year for 22 of 65 individuals (34%).
• Psychological evaluation reports had been completed in under one year for 31 of 65 individuals (48%).

In addition to providing intellectual and adaptive assessments, it is crucial to present those assessments in a manner that goes beyond the reiteration of scores and facilitates the identification of personal strengths and limitations. The Monitoring Team used the sample of two records reported above to determine the degree to which this was achieved.

<table>
<tr><th></th><th>3/2010</th><th>5/2013</th><th>11/2013</th></tr>
<tr><td>Psychological Assessments included a narrative summary of how the results from intellectual</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status				Compliance
		assessments would facilitate the understanding of the individual's strengths and needs.				
		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 Facility, it appeared that several limitations remained concerning Psychological Evaluation reports and the testing of individual abilities.

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. During the August 2012 site visit, it was suggested that a new SFA format and procedures reflected a substantial improvement over previous assessments. In May 2013, behavior assessments continued to be satisfactory, but substantial weaknesses were noted concerning the integration of behavioral and psychiatric services.

Current Site Visit

The Monitoring Team selected a sample of seven SFA reports from those reports completed since the last site visit. The specific individuals included in the sample were Individuals #4, #145, #48, #61, #123, #127, and #140. The table below summarizes the results from the review of those records.

	3/2010	5/2013	11/2013
Assessment or review of biological, physical, and medical status	0%	89%	100%
Review of personal history	0%	89%	100%
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	0%	89%	100%
The process or tool utilizes both direct and indirect measures	0%	89%	100%
Identification of setting events and motivating operations relevant to the undesired behavior	0%	89%	100%
Identification of antecedents relevant to the	0%	89%	86%

#	Provision	Assessment of Status	Compliance

undesired behavior			
Identification of consequences relevant to the undesired behavior	0%	89%	100%
Identification of functions relevant to the undesired behavior	0%	89%	100%
Summary statement identifying the variable or variables maintaining the target behavior	0%	89%	100%
Identification of functionally equivalent replacement behaviors relevant to the undesired behavior	0%	89%	100%
Identification of preferences and reinforcers	0%	89%	100%

The Facility continued to demonstrate skill in in relation to environmentally based behavior when conducting SFAs. The only item with a rating of less than 100% was in relation to the identification of antecedents. For that SFA, what was listed as an antecedent was a precursor behavior exhibited by the individual rather than an environmental stimulus that preceded the display of the target behavior.

During the current site visit, a sample of six SFA reports was used to assess the integration of mental illness and behavior assessments. This sample was the same as reported immediately above for the SFA review, minus one individual (Individual #123) who was not diagnosed with a mental illness. The findings of the review are presented in the table below.

	3/2010	5/2013	11/2013
The assessment process included screening for psychopathology, emotional, and behavioral issues.	0%	0%	50%
The assessment process included differentiation between learned and biologically based behaviors.	0%	0%	0%
Identification of behavioral indices of psychopathology	0%	11%	67%
Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities	0%	0%	50%

In comparison with previous site visits, there was some improvement noted regarding the integration of assessments targeting behavior and mental illness. Overall, however, the Facility continued to demonstrate considerable limitations in this area.

#	Provision	Assessment of Status	Compliance
		• For Individual #61, potential behavioral indices of mental illness were listed, but there was no discussion or investigation reported of whether these behaviors were actually related to the symptoms of mental illness. • For Individual #140, the only information provided in the SFA regarding mental illness was a listing of the individual's psychiatric diagnosis and most prevalent symptom. No discussion of the relationship between behavior and mental illness was provided. • For Individual #145, general statements were provided that posed questions about the relationship between compulsions and the targeted behavior of aggression. The SFA did not, however, did not reflect efforts to assess this potential relationship or further explore the interactions between behavior and mental illness. It should be noted that the weaknesses presented above pertain only to the assessments conducted and presented as part of the SFA process. In the overall monitoring of treatment, the Behavior Services staff and the psychiatrist were noted to conduct comprehensive and integrated procedures. For Provision J.8 of this report, the Monitoring Team indicated the following regarding psychiatric and behavioral services. "The Facility maintained a functional process that enables both the psychiatrist, and BCBA an opportunity to review each individual who is prescribed a psychotropic medication and collaborate in developing a combined behavioral and pharmacological treatment plan. For this reason, the Monitoring Team determined that the Facility is in substantial compliance with Section J.8." Observations and reviews of records reflected that the Facility had maintained previous levels of performance in behavior assessment and achieved some progress in relation to the integration of behavioral and mental illness assessment. Despite the noted progress, as well as the integration between Behavior Service staff and the Psychiatrist in other areas, the Facility continued to demonstrate substantial weaknesses. In order to obtain a rating of substantial compliance for this provision, the Facility will need to increase the investigation of behavioral correlates of mental illness and improve the documentation of those efforts in the SFA.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are	According to information obtained from the sample presented in K.5, as well as a review of the Facility tracking spreadsheet for psychological assessments and testing, the following conclusions were reached. • Intelligence tests had been completed within the past five years for 64 of 65	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>based on current, accurate, and complete clinical and behavioral data.</td><td>individuals (98%).
• Testing of adaptive skills had been completed at least annually for 22 of 65 individuals (34%).
• Psychological evaluation reports had been completed at least annually for 31 of 65 individuals (48%).

Based upon the information reviewed, it was evident that many of the psychological assessments at the Facility were neither current nor included complete clinical and behavioral data.</td><td></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>Tracking data provided by the Facility regarding on-going assessments, as well as assessment for those recently admitted to the Facility indicated the following.

<table><tr><th></th><th>3/2010</th><th>5/2013</th><th>11/2013</th></tr><tr><td>Individual records demonstrate that these psychological assessments are conducted as often as needed, and at least annually, for each individual.</td><td>0%</td><td>79%</td><td>66%</td></tr><tr><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>89%</td><td>0%</td><td>17%</td></tr></table>
Since the previous site visit, the Facility admitted seven individuals. Individual #6 had been admitted less than 30 days prior to the compliance visit. Review of the tracking data was done for Individuals #28, #45, #65, #119, #123, and #131. Tracking data revealed the following details.
• Four of six individuals (67%) had been provided an assessment of adaptive skills.
• Four of six individuals (67%) had been provided an assessment of intellectual ability.
• One of six individuals (17%) had assessments compiled and interpreted within a written assessment report.

Based upon available documentation psychological assessments were not based upon complete clinical and behavioral data.</td><td>Noncompliant</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>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.</td><td></td><td></td></tr>
<tr><td>K9</td><td>By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.</td><td>PBSP Approval and Consent
Historical Perspective
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. During the August 2012 site visit, consent forms were in 80% of records. By the May 2013 site visit, consents were in 86% of records.

Current Site Visit
During the current site visit, the Facility tracking spreadsheet was used to determine the status of PBSP consents. The documentation reflected that for 37 of the 49 PBSPs requiring consent (76%), the appropriate and current consents had been obtained.

<table><tr><th></th><th>3/2010</th><th>5/2013</th><th>11/2013</th></tr><tr><td>Necessary consents and approvals are obtained for each PBSP and safety plan prior to implementation.</td><td>78%</td><td>86%</td><td>76%</td></tr></table>
A review of Facility tracking data also reflected that RGSC experienced difficulty in implementing PBSPs promptly after approval and consent were obtained. For 40 of 49 active PBSPs (82%), there was a delay of greater than 14 days between consent and implementation. The average noted delay was 47 days.

PBSP Review
During the current site visit, the Monitoring Team selected a sample of seven individuals for the review of formal behavior interventions. These individuals included individuals with recent ISPs, behavior assessments, behavior interventions, or psychotropic medication reviews. The specific individuals included in the sample were Individuals #4, #48, #61, #123, #127, #140, and #145.

<table><tr><th>PBSP Element</th><th>3/2010</th><th>5/2013</th><th>11/2013</th></tr><tr><td>Rationale for selection of the proposed intervention</td><td>0%</td><td>89%</td><td>100%</td></tr><tr><td>History of prior intervention strategies and outcomes</td><td>0%</td><td>56%</td><td>100%</td></tr><tr><td>Consideration of medical, psychiatric and healthcare issues</td><td>0%</td><td>89%</td><td>100%</td></tr></table></td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Operational definitions of target behaviors</td><td>0%</td><td>89%</td><td>100%</td></tr>
<tr><td>Operational definitions of replacement behaviors</td><td>0%</td><td>89%</td><td>100%</td></tr>
<tr><td>Description of potential function(s) of behavior</td><td>0%</td><td>89%</td><td>100%</td></tr>
<tr><td>Use of positive reinforcement sufficient for strengthening desired behavior</td><td>0%</td><td>56%</td><td>100%</td></tr>
<tr><td>Strategies addressing setting event and motivating operation issues</td><td>0%</td><td>78%</td><td>100%</td></tr>
<tr><td>Strategies addressing antecedent issues</td><td>0%</td><td>78%</td><td>100%</td></tr>
<tr><td>Strategies that include the teaching of desired replacement behaviors</td><td>0%</td><td>67%</td><td>100%</td></tr>
<tr><td>Strategies to weaken undesired behavior</td><td>0%</td><td>89%</td><td>100%</td></tr>
<tr><td>Description of data collection procedures</td><td>0%</td><td>11%</td><td>100%</td></tr>
<tr><td>Baseline or comparison data</td><td>0%</td><td>89%</td><td>100%</td></tr>
<tr><td>Treatment expectations and timeframes written in objective, observable, and measureable terms</td><td>0%</td><td>89%</td><td>100%</td></tr>
<tr><td>Clear, simple, precise interventions for responding to the behavior when it occurs</td><td>0%</td><td>67%</td><td>100%</td></tr>
<tr><td>Plan, or considerations, to reduce intensity of intervention, if applicable</td><td>0%</td><td>89%</td><td>100%</td></tr>
<tr><td>Signature of individual responsible for developing the PBSP</td><td>0%</td><td>78%</td><td>100%</td></tr>
</table>

Based upon the available documentation, seven of seven PBSPs (100%) were rated as fully satisfying each of the items in the review.

Although the reviewed PBSPs were rated at 100%, the limitations pertaining to consent, timely approval, and timely implementation prevented the Facility from achieving a rating of substantial compliance for this Provision.
</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</td><td><u>Current Site Visit</u>
During the current site visit, the Monitoring Team selected a sample of six individuals for the review of PBSP data graphs. These individuals included individuals with recent ISPs, behavior assessments, behavior interventions, or psychotropic medication reviews. The specific individuals included in the sample were Individuals #5, #35, #45, #51, #55, and #84.

Based upon the selected sample, it was apparent that RGSC had maintained previous</td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>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>5/2013</td><td>11/2013</td></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Horizontal axis and label</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Vertical axis and label</td><td>0%</td><td>100%</td><td>83%</td></tr>
<tr><td>Condition change lines</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Condition labels</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Data points and path</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>IOA and data integrity</td><td>0%</td><td>0%</td><td>33%</td></tr>
<tr><td>Demarcation of changes in medication, health status or other events</td><td>0%</td><td>100%</td><td>100%</td></tr>
</table>

In six out of six 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>Inter-observer agreement exists for PBSP data</td><td>3/2010</td><td>5/2013</td><td>11/2013</td></tr>
<tr><td>IOA for target behavior data.</td><td>0%</td><td>0%</td><td>33%</td></tr>
<tr><td>IOA for replacement behavior data.</td><td>0%</td><td>0%</td><td>17%</td></tr>
<tr><td>IOA meets minimum criteria</td><td>0%</td><td>0%</td><td>17%</td></tr>
</table>

Other than the issues related to IOA and data integrity, the six 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>During the current site visit, the Monitoring Team selected a sample of 18 individuals for the review of the readability of formal behavior interventions. These individuals included individuals with recent ISPs, behavior assessments, or behavior interventions. The specific individuals included in the sample were Individuals #4, #12, #31, #36, #48, #63, #67, #72, #82, #91, #119, #123, #127, #134, #145, and #150. Review of the records for these individuals reflected an average readability score of grade 7.8, which was satisfactory.</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	The Facility submitted a list of staff trainings that had been conducted since the previous site visit. This list included 16 training sessions involving specific PBSPs. There was no indication of the training modalities that were used, which staff attended the training, or how well those staff learned and were able to demonstrate the skills being taught. 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 competency-based training for all staff working with a particular individual. • The Facility did not present a measure or system for assessing the competence of staff in relation to challenging behaviors that occur infrequently.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the site visit, the Facility employed two staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 32.5 individuals residing at the Facility and fell short of the required ratio of one BCBA for every 30 individuals. The Behavior Services department did not include a sufficient number of positions to achieve a 1:30 ratio. Should a BCBA credentialed employee fill each available position, the Facility would achieve approximately a 1:32.5 ratio, which was the current ratio. The Facility also employed sufficient Psychology Assistants to provide one Psychology Assistant for every two full-time psychologists.	Substantial Compliance

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-Assessment (11/6/2013) 2. RGSC Action Plan (11/5/2013) 3. Presentation Book, November 2013 4. RGSC Standard Operating Procedure ICF-IID 400 14; Medical Care, dated November 2004, revised July 2013 5. RGSC Standard Operating Procedure ICF-IID 400 16; Premedication for Medical and Dental Procedures, dated November 2014, and revised October 2013 6. RGSC Standard Operating Procedure EC403-02 Patient/Individual Immunization Program October 2011 7. RGSC Clinical Death Review – Investigative Offers Report Outline 8. RGSC High Profile Incident Report, 10/5/13 9. RGSC Death/Discharge Summary for Individual #40, 10/11/13 10. RGSC Ethics Committee Meeting minutes, 9/17/13 11. Individual #40 active record 12. Copy of medical licenses, CVs, and CPR certificate for medical providers. 13. List of all CME obtained by medical providers during the past 12 months. 14. Medical morning meeting minutes for the first meeting that occurred during April 2013 through November 2013. 15. Most recent IPNs for individuals #29, #79, #65, #8, #150, #40, #108, #61, #91, #2, #15, #126, #143, #91, #114, #45, #27, #3, and #81 16. List of all female individuals 40 years old, and older 17. List of all individuals who were current and not current with their annual mammogram screen 18. List of all men age 50 and older, and for the last ten individuals on the list: a. Copy of their PSA test results b. Documentation that the legally authorized representative (LAR) was informed of the risks, benefits, and alternatives to PSA testing c. Rationale why annual PSA testing was not completed 19. Complete vaccination records, and serology verification of immunization for Individuals #2, #15, #126, #143, #91, #114, #45, #27, #3, and #81 20. List of all individuals hospitalized during the reporting period and for Individuals #65, #150, #40, #108, and #61: a. Hospital admission and discharge summary b. Copy of medical provider's Doc-to-Doc communication c. Nurse liaison follow-up at hospital d. Post hospital Nursing Follow-up e. Post hospital IPN by the medical provider, through full resolution of the discharge condition 21. For individuals #29, #79, #65, and #8: a. Copy of all medical provider's IPNs, specific to the initial evaluation, and all subsequent follow-up IPNs through full resolution of the acute medical condition

	b. Copy of all related diagnostics specific to the evaluation, and follow-up of the acute medical condition c. All related consultation reports specific to the management of the acute medical condition 22. For Individual #108: a. Current annual medical assessment b. Current medication list c. Most recent quarterly medical review d. List of dates of all past history of bowel obstruction e. All medical provider's IPNs associated with the acute management of the bowel obstruction, through full resolution f. All specific consultation reports, and diagnostics specific to the management and follow-up of the bowel obstruction g. Copy of hospital admission and discharge summary h. Copy of most recent IRRF 23. For individuals #115, #85, #143, and #61: a. Most recent annual medical assessment b. Most recent quarterly medical assessment c. Current medication list d. Most recent IRRF e. Medical consultation reports specific to the management of CP, and/or Baclofen pump f. Most recent PT/OT treatment IPN specific to the management of CP g. Most recent PT/OT assessment h. ISP, or other relevant documentation indicating all necessary supports and services for the management of CP i. ISP or other relevant documentation indicating how CP affects the Individual's life and expected prognosis 24. For individuals #4, #85, #143, #86, and #126: a. Most recent medical assessment b. Quarterly physician assessments for past six months c. All documentation indicating assessment for the etiology of low bone density d. Most recent IRRF e. Current medication list f. Labs for past 12 months g. Consultation reports specific for the evaluation, and/or treatment of osteoporosis h. All diagnostic studies to assess for bone density, for the past three years 25. Alpha list of all fractures that occurred during the reporting period 26. For Individuals #4, #15, #84, and #72: a. Most recent annual medical assessment b. Past six months quarterly medical assessments c. PT/OT assessments, and IPNs specific for the management of fracture d. Medical provider's IPNs specific for the assessment and management of fracture e. Medical provider's IPN documenting the possible etiology of the fracture

	f. Most recent two IRRFs g. IDT minutes, ISP, or other documentation indicating an IDT review of the fracture h. Most recent bone density i. Most recent medication list 27. Alpha list of all individuals diagnosed with a seizure disorder 28. For individuals #86, #118, #74, and #19: a. Annual medical summary b. Most recent two quarterly physician summaries c. Most recent two neurology consultation reports d. Current medication list e. Most recent EEG f. Most recent brain imaging report g. Current six months medical provider's IPNs, specific for management of seizure disorder h. IDT meeting minutes documenting supports and services necessary for the management of seizure disorder i. Seizure log 29. DADS Policy: Medical Provider External/Internal Audits, revised July 6, 2012 – no number 30. The Facility provided Analysis of Internal/External Medical Provider Audit: Round 7, for the time period August 2012 through April 2013 31. Analysis of Internal/External Medical Provider Audit: Round 7, for the time period February through April 2013 32. Action plan, and action plan follow-up for round 7 of the internal and external medical audits. **People Interviewed:** 1. Interview with Dr. David Moron, Clinical Director 2. Interview for assessment of the Facility's mortality review process: Medical Director Maria Dill, M.D. , Clinical Director David Moron, M.D., ICF-IID Program Director Lorraine Hinrichs, Chief Executive Nurse Anne Menz, RN, Ph.D., Nursing Operations Officer Robin Martin, RN, MSN, Assistant Facility Director Blas Ortiz, Quality Management Director Mary Ramos, and Quality Enhancement Nurse Belinda Portales, RN **Meeting Attended/Observations:** 1. Observation of living areas El Paisano and La Paloma 2. Annual ISP planning meeting for Individual #74 3. Admission ISP planning meeting for Individual #28 4. Interdisciplinary Team (IDT) meeting for Individual #46 5. Morning Medical Meeting 11/21/2013
	Facility Self-Assessment: The Facility determined noncompliance for Sections L.1 through L.4, and the Monitoring Team concurs with that assessment. For Section L.1, the Facility did not utilize appropriate data to assess compliance. For example, the Facility reported that 100% of individuals reviewed demonstrated "proper management of diabetes" in 100% of

	the cases reviewed; however, the self assessment did not utilize outcome measures to determine if diabetes was appropriately managed. The self assessment also determined that 100% of individuals "had their immunizations administered as indicated"; the Monitoring Team, however, noted that many individuals did not have appropriate documentation for MMR and polio, and that lot numbers and expiration dates of administered vaccines were not consistently documented, per CDC recommendations. The Facility should determine specific outcome measures for medical conditions that would demonstrate that generally accepted standard of care is practice at the Facility. For Sections L.2 and L.3, the self-assessment did not assess the effectiveness of the medical audit process and the Facility had copied and pasted the result of the audit process, as its self-assessment. The Facility should assess the actual process to determine its effectiveness. For Section L.4, the self-assessment did not utilize data, but indicated that various policies were in place. The Facility should assess all relevant policies and procedure to ensure their relevance, and assess to see if the Facility is in compliance with the policies and procedures.
	Summary of Monitor's Assessment: The Monitoring Team concurs with the Facility's determination of noncompliance with Sections L.1 through L.4. The Monitoring Team noted that the Facility promptly addresses acute medical conditions, documents clinical issues by dictation and in SOAP format, and provides timely screening for prostate and breast cancer. The Facility was noted to have continued issues with regards to following up on medical conditions, medical provider's participation at IDT meetings, and the annual ISPs and its mortality review process. The Facility must also develop and implement necessary policies and procedures for medical services, and enhance the medical audit process. The following are some specific comments for Sections L.1 through L.4: Section L.1: The Monitoring Team concurs with the Facility's findings of noncompliance with Section L.1. The Facility continued to demonstrate prompt and efficacious management of acute medical conditions, and effective documentation practices. The Facility must enhance its ability to address chronic care issues, such as seizure disorder, osteoporosis, cerebral palsy, and fractures, among others. The medical provider should ensure follow-up to all acute medical conditions through full resolution of the condition. The medical providers, and the medical component of IDT meetings and the ISP must be enhanced, and the medical provider must ensure understanding of all known medical conditions, and convey all necessary supports and services needed to manage each medical condition to the IDT members. Section L.2: The Facility must enhance its mortality review process by ensuring that the mortality review committee has a comprehensive understanding of the underlying medical, and any related behavioral, conditions associated with the cause of death, and determine if all reasonable interventions were considered by the IDT. The current medical provider audit process does not assess clinical performance outcomes, and mostly assesses if the medical provider follows Facility procedures. The audit process should include a substantial component that assesses if the medical provider is practicing at the current generally accepted professional standard of treatment for the medical condition, understands the etiology

	of diagnosed conditions, and if appropriate supports, and services are efficacious. For these reasons, the Monitoring Team determined noncompliance with Section L.2. Section L.3: The Monitoring Team noted that internal medical audits were conducted as scheduled, and the action plans developed for missed items were not completed. As per Section L.2, of this report, the Monitoring Team has concern over ability of the medical audit process to assess clinical performance of the medical providers. 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; and develop a system to track clinical indicators to identify areas that require improvement. The Monitoring Team determined that the Facility is not in compliance with Section L.3. Section L.4: The Facility continues to be noncompliant with Section L.4 because it has not developed and implemented essential policies and procedures to ensure that medical care is consistent with generally accepted professional standards of care.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Provision L.1 comprehensively assesses the Facility's ability to provide medical care, at the level of generally accepted professional standard of care practice. To assess the Facility's effort towards substantial compliance for Provision L.1, the Monitoring Team discussed medical compliance issues with the medical director; met with members of the Facility's medical staff; observed the Facility's clinics; and attended medical meetings, an annual individual support planning meetings (ISP), and other IDT meetings. Through document review, the Monitoring Team assessed the Facility's medical administration; immunization and vaccination process; cancer screening; practice for do not resuscitate orders; clinical management of acute medical conditions; management of seizure disorder, and Vagal Nerve Stimulators; recurrent pneumonia; osteoporosis; management of fractures; post hospital follow-up care; bowel obstruction; and cerebral palsy, and spasticity. <u>Medical Administration</u> The Monitoring Team assessed licensure status of the Facility's medical staff, CPR certification, clinical documentation practice, and the Facility's regularly scheduled interdisciplinary meetings. To help with the assessment the Monitoring Team reviewed the following documentation: • List of all medical providers, including number of hours worked, case load, and employment status • For each medical provider o Curriculum vita for all licensed medical providers	Noncompliance

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		o Copy of current medical license for two medical providers o Copy of current CPR certificate for all medical providers (the Monitoring Team requested all but received two) o List of all CME obtained during the past 12 months for all medical providers • Copy of morning medical meeting minutes for the first meeting of each month during the reporting period. Medical Providers: The Facility maintained one full time clinical director,]one part time staff physician, and a full time locum physician. The clinical director provided administrative services only, and did not provide direct clinical care; hence, the Facility maintained 1 1/2 full time equivalent medical providers who provided direct care. Medical licenses were reviewed, and noted to be current for all licensed medical providers and the clinical director. A copy of a current CPR certificate was provided for one of the two medical providers who provide direct care. There was no evidence of CME being provided for specific clinical issues related to developmental disabilities. <u>Medical Meetings</u> The Facility conducted a daily Morning Medical Report meeting, which is conducted five days per week. It is reported to be an integrated, multidisciplinary meeting that consists of medical providers, unit nursing staff, and representatives from various departments, including PT/OT, behavioral health, residential services, psychiatry, dietary services, quality assurance. The purpose of the meeting is to triage and discuss urgent clinical issues to ensure continuity of care, and to enhance clinical management of individuals. Issues discussed include, but are not limited to: Medical on call report; hospital report; clinic report; psychiatric; behavioral health related issues; pending medical consultations; wound care, and infectious disease issues; and significant medical conditions. Review of the meeting minutes for the Morning Medical Report meetings that occurred from on the first Monday of each month, from April 2013, through October 2013 indicated very limited incidences reported by the living areas; there was no indication that specific staff members were assigned responsibility to follow-up on clinical issues reported, and specific follow-up dates were not listed. The Monitoring Team attended the 11/21/2013 meeting, and noted a significant paucity of inter-disciplinary collaboration among participants; including the medical provider and nursing staff. The meeting consisted mostly of living area staff reading a list of clinical events that occurred on the day prior to the meeting. There was no evidence of	

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		meaningful discussion, nor were specific action plans developed to address reported clinical issues. Summary: The Facility did not provide copies of CPR for all practicing medical providers for review. The Morning Medical Report meeting was determined to be ineffective, as it did not demonstrate interdisciplinary collaboration among participants, and relevant clinical issues were not followed up upon as an action plan. Clinical documentation: The Monitoring Team reviewed the medical provider's most recent integrated progress note (IPN) for individuals #29, #79, #65, #8, #150, #40, #108, #61, #91, #2, #15, #126, #143, #91, #114, #45, #27, #3, and #81. The IPNs were all dictated and transcribed, and followed the SOAP format for clinical documentation. All IPNs clearly documented the reason for the assessment, objective findings, a concise focal examination, and a plan. Summary: The Facility's documentation by the medical provider clearly meets standard of care practice, and the Monitoring Team is complementary on enabling dictation, and consistency of its clinical documentation practice. <u>Medical Provider's Participation in the Interdisciplinary Team Process (IDT)</u> The Monitoring Team attended a 30-day ISP meeting for Individual #28, a special IDT meeting for Individual #46, and an annual ISP meeting for Individual #74. Individual #74: From a medical perspective, the Monitoring Team had significant concern that the medical provider was unaware of the circumstances, and clinical issues related to a recent hospitalization for ST elevation, and that several medical conditions were not identified or readily explored by the IDT. For example, the IDT met without having reviewed the seizure data, and when the issue of seizures was raised by the guardian, the Facility was unable to explain the reported increased seizure activity, that could have resulted from the multiple recent anticonvulsant medication changes. The IDT did comment on an anticonvulsant reduction that took place over one year ago, but not the more significant changes that took place over the previous six month period. Also, several clinical issues were not listed on the draft ISP, or on the previous annual ISP, despite the clinical issues being well documented in the clinical record. For examples, the diagnosis of GERD, history of anal fistulectomy and sphrincterotomy were not on the previous annual ISP, or the current draft ISP. Individual #46: A special ISP was conducted secondary to worsening respiratory compromise. It appeared to the Monitoring Team that the IDT was unaware of important medical diagnoses, and specific recommendations made by medical specialists. For example, the Individual had two sleep studies, one week apart, that demonstrated severe	

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		sleep apnea, and benefit by the use of C-PAP. The medical consultant made specific recommendations per two sleep study consultation reports. Initially during the IDT meeting the IDT members demonstrated no awareness that two sleep studies were previously completed, that the Individual benefited from C-PAP, and that there were specific medical recommendations for treatment, including life style changes, limiting caffeinated beverages, no sedating medications, sleep hygiene procedures, evaluation of certain laboratory studies, and to obtain a C-PAP device; the IDT members only became aware of this late in the meeting when the reports were reviewed. Also, during the meeting, a member of the IDT was proposing to have the individual sleep in the head-down position, which was contraindicated secondary to the Individual's known GERD and a specific recommendation by the medical consultant to ensure that the Individual slept with the head elevated at least 30 to 60 degrees. Individual #28: This was a 30-day admission ISP meeting. The medical provider was not present at the meeting; however, the psychiatrist did attend the meeting. The Monitoring Team was impressed that the psychiatrist addressed all relevant clinical issues. For example, the psychiatrist addressed movement disorder, medical conditions that could contribute to psychiatric manifestations, such as hypothyroidism, and reviewed the Individual's polypharmacy, with indication of reducing polypharmacy in the future. There were several conditions noted that were not addressed by medical provider's IPNs or admission medical assessment. For example the Individual was reported to have blood in his stool in the past, had low vitamin D level, and had an indeterminate hepatitis B result. These issues should have been addressed by the medical provider and a plan in place for the IDT to review. Furthermore, the IDT, without input by the medical provider, determined that because the Individual was young, he was at low risk for osteoporosis; the IDT did not consider low vitamin D level or the individual's psychotropic polypharmacy, which is known to cause osteoporosis, as risk factors for osteopenia and osteoporosis. The Monitoring Team was concerned that specific issues including the Individual's statement of possessing a firearm in the past, known physical aggression, and the individual's unsubstantiated report of polysubstance abuse were not well explored by the IDT members prior to developing a plan for community integration. Summary: The Monitoring Team determined that the Facility does not provide effective involvement of medical staff in IDT meetings nor effective review and planning of medical services and supports in the ISP planning meeting. The Facility must enhance the medical provider's involvement with the IDT process, and ensure the medical provider understands and communicate all clinically relevant information to the IDT; and that the IDT members are well prepared for the IDT meeting by reviewing all relevant information prior to the IDT meeting.	

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		Cancer screening The Monitoring Team assessed the Facility's ability to provide screening procedures for cancer by reviewing the Facility's screening process for mammography and PSA screening. Mammography: To assess the Facility's breast cancer screening process, the Monitoring Team reviewed: • List of all female individuals 40 years old, and older • List of all individuals who were current and not current with their annual mammogram screen • Documentation by the Facility indicating the rational why individuals were not current with their annual mammogram screen The Facility provided a list of all females, age 40 years and older, and lists of females who have had screening mammograms completed within the past 12 months, and who had not had screening mammograms completed within the past 12 months. The Facility reported a total of 17 individuals who were age 40 and older. Of the 17 individuals, the Facility provided copies of current mammograms indicating that 11 individuals had a screening mammogram within the past 12 months (65%). The Facility provided documentation indicating that the mammograms for three individuals were pending, secondary to recent refusal by the individuals; one individuals could not participate with screening mammography because of body habitus; one individual was 72 years old and did not require screening mammogram; and for one individual, scheduled screening mammogram was scheduled for shortly after the Monitoring Team's on-site review. The Monitoring Team noted that the Facility provides regular mammogram screening for breast cancer to individuals, when clinically indicated. Prostate cancer screening by PSA blood test: The Monitoring Team reviewed the following documents to assess the Facility's prostate cancer screening program, by means of PSA blood testing: • List of all men age 50 and older • For the last ten individuals on the list: o Copy of their PSA test results o Documentation that the legally authorized representative (LAR) was informed of the risks, benefits, and alternatives to PSA testing o Rationale why annual PSA testing was not completed Of the ten examples reviewed, eight out of ten (80%) indicated that annual PSA testing	

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		was completed. There was no clinical rationale provided documenting why PSA testing was not obtained for two of the ten individuals who were age 50, and older. There was no evidence provided demonstrating the Facility's discussion with the LAR about the potential risks, benefits, and alternative to PSA testing. Acceptable standard of care practice dictates that the LAR be informed of the risks, benefits, and alternatives to PSA testing. The Monitoring Team compliments the Facility for ensuring PSA screening; however, the Facility must ensure that prostate cancer screening be discussed with the LAR, and that potential risks, benefits, and alternative to PSA screening were discussed. <u>Review of Do Not Resuscitate (DNR) Process</u> To assess the Facility's DNR process, the Monitoring Team requested the following information: • List of all individuals who were prescribed a DNR order • For all individuals on the list of DNRs o Most recent annual medical assessment o Most recent ISP, or other relevant documentation indicating and interdisciplinary team (IDT) review o Copy of ethics review for the DNR o Copy of the consent for DNR o Copy of the completed DNR form o Copy of specific instructions to direct care, and other staff, regarding the DNR o Copy of the medical providers interdisciplinary progress notes (IPN) documenting the clinical rational for the DNR The Facility did not provide documented information related to its DNR process. Summary: The Facility must have a functional DNR process in place that enables full or limited DNRs for individuals with known terminal conditions. The Monitoring Team will explore all policies, procedures, and ethics review process at the next compliance visit. <u>Review of Immunizations</u> To assess the Facility's compliance with CDC guidelines for immunization, the Monitoring Team reviewed the following documents: • Complete vaccination records, and serology verification of immunization for the first individual on the current name key, as of this review, and then every fifth	

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		individual, for a total of ten examples (Individuals #2, #15, #126, #143, #91, #114, #45, #27, #3, and #81). o If not current with vaccination schedule, indicate the clinical rationale for not following CDC guidelines for immunization. • Facility's policy for vaccination and immunization. The Facility provided standard operating procedure EC403-02: Patient/Individual Immunization Program, revised October 2011. The procedure did not comment on documentation practice demonstrating immunization and vaccination status, or its consent process specific to vaccination. The following is a summary of the Monitoring Team review of vaccination, and immunization records for Individuals #2, #15, #126, #143, #91, #114, #45, #27, #3, and #81: • The vaccination records reviewed consistently documented lot numbers of vaccines, expiration dates, and site of administration in zero out of ten examples (0%). • The vaccination and immunization records were clearly documented in zero out of ten examples (0%). Vaccination records consisted of multiple pages of a duplicated form. For example, there were multiple pages that included a space for polio to be documented, and only one of the pages would be completed for polio vaccination status. • Three out of ten examples (30%) demonstrated documented evidence, that included dates and lot numbers, of full vaccination series administered for immunization for measles, mumps and rubella. • One of ten examples (10%) documented evidence of vaccination or immunization for polio. In the majority of examples reviewed, such as in the case for Individuals #126, and #91, the nurse simply documented the statement "copied from record", and did not include specific information for the administered vaccine. A vaccination record must contain all relevant information, such as lot number, and date administered. • Ten out of ten examples (100%) had influenza vaccine in 2012. • Ten out of ten examples (100%) documented vaccination with TDap within the last ten years. Summary: The Facility must enhance its immunization program by ensuring strict adherence to CDC guidelines for immunization and vaccination. It would be advantageous for the Facility to ensure that there is clinically appropriate documentation for all recommended vaccinations, and follow CDC "catch up" recommendations, when necessary. The Monitoring Team also strongly recommends the Facility develop a policy	

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		and procedure for its immunization and vaccination practices that is consistent with CDC guidelines for vaccination, documentation, verification, and consent process for vaccination, and immunization. <u>Hospitalizations</u> Between 4/1/2013 and 11/12/2013, the Facility reported a total of 18 admissions to an acute hospital. Four of the individuals experienced two or more acute hospitalizations during this period. From a list of the reported hospitalizations, the following information for the first, and then every third individual, for a total of five examples, was reviewed (Individuals #65, #150, #40, #108, and #61): a. Hospital admission and discharge summary b. Copy of medical provider's Doc-to-Doc communication c. Nurse liaison follow-up at hospital d. Post hospital Nursing Follow-up e. Post hospital IPN by the medical provider, through full resolution of the discharge condition The following is the Monitoring Team's assessment of the Facility's ability to manage acute hospitalizations for individuals #65, #150, #40, #108, and #61: • Four out of five examples (80%) included a comprehensive hospital transfer note, completed by the nurse. The Monitoring Team was, however, concerned that a copy of the actual transfer note was not provided for review, and only a copy of the electronic record documenting what the nurse reported to the acute care hospital was provided as part of this document request. Subsequent compliance visit will require that a copy of the actual transfer note be provided for review. • Five out of five examples (100%) included comprehensive nurse liaison notes, documenting the complete hospital stay. • One out of five examples (20%) included a comprehensive nurse liaison post hospital discharge note. • Five out of five examples (100%) included a note by the medical provider, indicating a post hospital assessment. • Zero out of five examples (0%) included a note by the medical provider, indicating a Doc-To-Doc discussion with the hospital medical staff. • One out of five examples (20%) included medical provider's post hospital IPNs, documenting the discharge condition, through resolution. There was evidence that five out of five examples included a comprehensive, and clinically relevant post hospital discharge note; however, only one example (Individual #65) included medical provider's IPNs documenting further follow-up on post hospital clinical	

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		issues. • The IDT conducted a post hospital review for four out of five examples (80%). There was no evidence provided that the IDT met to discuss post hospital issues for Individual #61. The Monitoring Team observed a special IDT meeting for an Individual Support Plan Addendum (ISPA) Individual #46. The physician decided to send Individual #46 to the emergency room for further evaluation and treatment. The Transfer Form was completed and sent with Individual #46 to the emergency room. Upon return from the emergency room the same day, a Post-Hospital/ER/LTAC Nursing Assessment was completed as required. Of significant concern to the Monitoring Team was the lack of meaningful review, and recommendations for the post hospital IDT follow-up of Individual #40. The Individual was noted to have significant health care issues, that were potentially terminal, and there was no discussion about DNR status, and the IDT did not conduct a comprehensive review of all potential treatments, and obtain necessary external consultations to address possible means of enhancing behavioral interventions, which could possibly improve compliance with medical treatments. Summary: The Facility's medical provider regularly performed comprehensive post hospital discharge assessments, and the Facility routinely followed up on individuals during an acute hospital admission. The Facility must ensure that a Facility medical provider makes direct contact with the hospital admitting physician, or other relevant hospital staff, to better ensure continuity of care. The medical provider must document necessary IPNs documenting regular follow-up on all post hospital clinical issues, through full resolution of the condition. The IDT must enhance its review process of clinical issues, to ensure that all clinical issues are thoroughly explored to all IDT members, and ensure that all necessary supports and services are in place to address all clinical issues. <u>Follow-up to acute medical conditions</u> To assess the Facility's ability to manage acute medical conditions, the Monitoring Team requested for review the following documents for the first reported acute medical condition that occurred for each month during the reporting period, for a total of five examples. • Copy of all medical provider's IPNs, specific to the initial evaluation, and all subsequent follow-up IPNs through full resolution of the acute medical condition • Copy of all related diagnostics specific to the evaluation, and follow-up of the acute medical condition	

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		• All related consultation reports specific to the management of the acute medical condition The Facility reviewed four of these examples of acute medical conditions (Individuals #29, #79, #65, and #8), and of these four examples: • Four out of four (100%) included a comprehensive and clinically appropriate initial assessment of the acute medical condition. • Of the four examples, three examples were determined by the Monitoring Team to require medical follow-up through resolution. Of the three examples, there was evidence indicating that one out of the three (33%) documented continued physical assessments by the medical provider through resolution. • Four out of the four examples (100%) documented clinically appropriate consultative referrals and, or diagnostics. Summary: Of the examples reviewed, the Monitoring Team noted that initial assessments by the medical provider were timely, clinically appropriate, and indicated the need for consultations and, or diagnostics, when clinically necessary. The Facility did not provide evidence to support the medical provider's follow up on the acute medical condition through full resolutions. <u>Clinical management of bowel obstruction</u> To assess the Facility's clinical management of individuals with bowel obstruction, the Monitoring Team requested an alpha list of all individuals who experience an episode of bowel obstruction, or bowel perforation; and for the last five individuals on the list: • Current annual medical assessment • Current medication list • Most recent quarterly medical review • List of dates of all past history of bowel obstruction • All medical provider's IPNs associated with the acute management of the bowel obstruction, through full resolution • All specific consultation reports, and diagnostics specific to the management and follow-up of the bowel obstruction • Copy of hospital admission and discharge summary • Copy of most recent IRRF • Copy of IDT minutes documenting the IDT review of the bowel obstruction The Facility reported that one individual (Individual #108) experienced a bowel obstruction during the reporting period.	

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		Individual #108: Upon noted abdominal distention, and episode of vomiting, the PCP was notified, and clinically appropriate diagnostics, including a CT of the abdomen, were ordered. Within one hour of the CT scan, the hospital forwarded the result of possible bowel obstruction to the Facility's medical provider, who immediately triaged the Individual for further assessment and treatment at the local acute care hospital. Within 24 hours following discharge from the hospital, the medical provider performed a complete physical assessment, and reviewed the hospital's discharge orders. Furthermore, the Facility conducted an IDT meeting to discuss the Individual's bowel obstruction, enhanced monitoring by direct care and nursing staff, ensured that appropriate medications were in order, and upgraded the IRRF rating for constipation and bowel obstruction to high. There was no evidence provided that documented periodic assessment by the medical provider of the Individual's known diagnosis of constipation, such as documentation of reviewing bowel tracking sheets. Also, the Individual was known to have a history of foreign body ingestion, and per review of the annual medical assessment, annual ISP, and post hospital ISP addendum, there was no comment noted addressing the possible diagnosis of pica, or need to monitor the Individual for foreign body ingestion. The Monitoring Team could not identify a specific review of potential pro-constipating medications, and given that the Individual is provided calcium citrate, which is known to cause constipation, and has an FDA caution warning for use in individuals with known bowel obstruction, the risks and benefits for continued use of calcium citrate should have been addressed at the IDT meeting. Summary: The Monitoring Team noted clinically appropriate management of the acute management of bowel obstruction. The Monitoring Team strongly recommends that all known and potential risk factors associated with constipation be fully evaluated by the medical provider and reviewed by the IDT, especially pro-constipating medications, and any known history of foreign body ingestion. <u>Clinical management of cerebral palsy (CP)</u> To assess the management of CP, and baclofen pumps, the Monitoring Team requested the following information: • Alpha list of all individuals with diagnosis of CP • Alpha list of all individuals with implanted Baclofen pump • Alpha list of all individuals screened for possible need of a Baclofen pump • For the first, and then every second individual on the alpha list of individuals with CP, for a total of five examples: o Most recent annual medical assessment o Most recent quarterly medical assessment o Current medication list	

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		o Most recent IRRF o Medical consultation reports specific to the management of CP, and, or Baclofen pump o Most recent PT/OT treatment IPN specific to the management of CP o Most recent PT/OT assessment o ISP, or other relevant documentation indicating all necessary supports and services for the management of CP o ISP, or other relevant documentation indicating how CP affects the Individual's life, and expected prognosis The Facility indicated that eight individuals were known to have a diagnosis of CP, and that no individuals were prescribed, or assessed for a Baclofen pump. The Facility provided clinical documents for Individuals #115, #85, #143, and #61: • The diagnosis of CP was noted on the annual medical assessment in four out of four examples (100%). • There was a comprehensive plan documented on the annual medical assessment specific to the management of CP in zero out of four examples (0%). The plans documented were very basic and indicated to either continue current management, or "will get PT eval". All necessary monitoring parameters, necessary treatments, and consultations should be well documented as part of the clinical plan. • There was a well-documented assessment for spasticity on the annual medical assessment, as part of the physical examination, in zero out of four examples (0%). • The Medical provider documented regular assessments for the potential manifestations of CP in zero out of four examples (0%). • Medical consultations were provided to address manifestations of CP, such as spasticity in zero out of four examples (0%). • The ISP or other relevant documentation indicated that the IDT had a comprehensive understanding of CP, and how CP affects the Individuals life in zero out of four examples (0%). • The ISP and/or the IRRF documented all necessary supports and services for CP and spasticity in zero out of four examples (0%). • There was medication, such as Baclofen, Botox, or Baclofen pump for spasticity in zero out of four examples (0%). • The PT/OT assessment indicated specific measurements when assessing spasticity in zero out of four examples (0%). • There was evidence that specific PT/OT treatments were provided to help minimize progression of contractures in zero out of four examples (0%).	

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		The following are examples of some of the Monitoring Team's concerns for two examples reviewed: Individual #115: Has diagnosis of CP. Most recent PT/OT assessment reported within the body of the assessment that the Individual has spasticity of the hip and knee, however, no diagnosis of spasticity was noted on the PT/OT report, or annual medical assessment. The PT/OT assessment did not comment on range of motion measurements. There was no evidence that the medical provider performed assessments for manifestations of CP, and spasticity was not diagnosed on the annual medical assessment. The Individual was referred to an orthopedist in 2011, for ankle contracture, and surgery was recommended. There was no evidence that the surgery was completed, and the annual IDT, medical assessment, and PT/OT assessment did not comment on the recommendation for surgical correction. Furthermore, because of worsening falls the IDT recommended follow-up with a physiatrist in May 2013, but there was no evidence that this consultation occurred. Review of the medication history indicated that there were no medications prescribed for spasticity. Individual #85: Has a diagnosis of CP. Most recent PT/OT assessment reported within the body of the assessment that the Individual has spasticity of the right upper and lower extremity, but no diagnosis of spasticity was noted on the PT/OT report or annual medical assessment. There was no evidence that the medical provider performed assessments for manifestations of CP, and spasticity was not diagnosed on the annual medical assessment. Review of the medication history indicated that there were no medications prescribed for spasticity. The ISP and IRRF did not reflect that the IDT reviewed support and service needs associated with CP, or how CP will affect the individual's life. There were no specific diagnostics or consultations specific for the evaluation and management of CP. Summary: The Monitoring Team determined that the Facility did not assertively manage chronic issues associated with CP. The Facility must routinely assess the individual for all possible manifestations secondary to CP, and ensure that all necessary supports and services, including assistive devices and medication, are considered. CP is not a static condition, and there are significant changes that manifest over the individual's lifetime, and this condition must be assessed, and when clinically appropriate, be provided the necessary medical intervention. PT/OT must regularly assess actual range of motion measurements, in order to assess worsening contractures, and spasticity. <u>Clinical management of osteoporosis</u> To assess the Facility's ability to clinically assess and treat osteoporosis, the following	

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		documents were requested, and reviewed: • Alpha list of all individuals with a diagnosis of osteoporosis • For the first two and last three individuals on the list (Individuals #4, #85, #143, #86, and #126): o Most recent medical assessment o Quarterly physician assessments for past six months o All documentation indicating assessment for the etiology of low bone density o Most recent IRRF o Current medication list o Labs for past 12 months o Consultation reports specific for the evaluation, and/or treatment of osteoporosis o All diagnostic studies to assess for bone density, for the past three years The Facility indicated that ten individuals were diagnosed with osteoporosis at the Facility. The following are the Monitoring Team's findings from review of the documents related to the management of the assessment and treatment of osteoporosis (individuals #4, #85, #143, #86, and #126): • Five out of five examples (100%) included annual medical summaries that indicated a clinically appropriate diagnosis for osteoporosis on the active problem list. • In zero out of five examples (0%) the annual medical summaries indicated a clinically appropriate action plan for osteoporosis. The clinical plan should include the specific recommended treatment, planned diagnostic follow-up, specific monitoring parameters for staff, and necessary supports and services. • Zero out of five examples (0%) included documentation indicating a clinical evaluation for the etiology of low bone density. It should be noted that the Facility provided a document that indicated that the etiology for underlying low bone mineral density was not evaluated. • Three out of five examples (60%) included evidence that a clinically appropriate diagnostic was obtained to assess bone density, and treatment efficacy, when clinically indicated. There was no evidence provided for Individual #126, and the most recent BMD study provided for Individual #85 was from 2008. • Five out of five examples (100%) included evidence that a clinically appropriate pharmacological therapy was provided, as clinically necessary, to treat low bone density. • Five out of five examples (100%) included osteoporosis as a risk factor on the	

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		most recent IRRF. Summary: The Monitoring Team recommends occasional assessment of bone mineral density to assess efficacy of therapeutic efforts. Also, clinical plans should well document specific treatments, monitoring parameters, and all necessary support and services that must be provided. Per Provision N, of this report, fifty individuals at the Facility are on psychotropic drugs, many of which cause loss of bone mineral density; the Monitoring Team is concerned that only ten Individuals have been diagnosed with osteoporosis. <u>Clinical management of fractures</u> The Facility reported ten individuals as having a fracture during the reporting period. To assess the Facility's clinical ability to manage fractures, the Monitoring Team requested the following information: • Alpha list of all individuals who sustained a fracture during the reporting period • Committee meeting minutes, and all other relevant documents indicating a Facility systems review of fractures, and attempts to mitigate fractures • For the first two and last three individuals on the list of fractures (Individuals #4, #15, #84, and #72; the Facility provided four examples to review): o Most recent annual medical assessment o Past six months quarterly medical assessments o PT/OT assessments, and IPNs specific for the management of fracture o Medical provider's IPNs specific for the assessment and management of fracture o Medical provider's IPN documenting the possible etiology of the fracture o Most recent two IRRFs o IDT minutes, ISP, or other documentation indicating an IDT review of the fracture o Most recent bone density o Most recent medication list Although trends analysis was provided for falls, the Facility did not conduct a systems review for fractures; the Facility did not provide relevant committee meeting minutes or trends analysis of fractures that occurred during the reporting period. The Monitoring Team strongly recommends that the Facility develop a mechanism to provide periodic reviews of all fractures, per a systems review, that includes a trends analysis for fractures. The following is a summary of the Monitoring Team's findings, following its review of the	

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		four examples provided: • In three out of four examples (75%) the medical provider conducted a prompt initial triage for reported fractures. • In two out of four examples (50%) the medical provider regularly followed the Individual through full resolution of the fracture. • In four out of four examples (100%) the medical provider obtained necessary diagnostics and prompt consultation for the assessment and treatment of fracture. • In zero out of four cases (0%), the Medical provider documented a comprehensive assessment of all risk factors for fall and fracture. • In zero out of four cases (0%), PT/OT documented a comprehensive assessment of all risk factors for fall and fracture. • In zero out of four cases (0%), the IRFF documented a comprehensive assessment of all risk factors for fall and fracture. • In zero out of four cases (0%), there was documentation on the annual medical summary, PT/OT assessments, and ISPs, indicating that prescribed supports and services to help prevent falls and fractures were routinely assessed for efficacy, based on known risk factors. There were no examples of the medical provider's conducting quarterly medical assessments. And PT/OT assessments and annual medical summaries reviewed did not specifically document all necessary supports and services necessary for prevention of falls and fractures. Each example reviewed demonstrated many risk factors for falls and fractures that were not documented by the IDT, including the medical provider. It is essential that the medical provider and the IDT clearly identify all known risk factors for falls and fractures, stratify the associated risks, and develop a specific plan to help mitigate falls and fractures. The following are some specific concerns noted by the Monitoring Team: • Individual #72: This Individual has a diagnosis of seizure disorder, is on anticonvulsants, has a known gait instability, is osteoporotic, had avascular necrosis of the left hip, right hip arthritis, and has one leg that is shorter than the other. All of these factors will contribute potential falls and related fractures. The ISP must specifically address these risks, and a specific plan must be developed to help minimize the potential of fall and fracture, for each risk factor identified. • Individual #4: The Individual has a diagnosis of osteoporosis, degenerative joint disease, known to have deformed foot, had a cerebral vascular accident, and is on medications that can manifest in falls. The ISP and IRRF did not specifically address important risk factors, such as osteoporosis, degenerative joint disease, history of cerebral vascular disease, or how medications can manifest in falls.	

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		Summary: The Monitoring Team strongly suggests that the Facility develop a specific mechanism to perform regular systems review, consisting of trends analysis for fractures that occur at the Facility. In addition, the Facility must better identify risks associated with fractures, and ensure that a plan is in place to help mitigate falls and fractures, secondary to known risks. <u>Review of the Facility's clinical management of pneumonia</u> The Facility provided documentation indicating that there were no cases of pneumonia diagnosed or treated during the reporting period; therefore, the Monitoring Team was unable to comment on the Facility's management of pneumonia. The Facility provided documentation indicating a systems review of pneumonia, including trends analysis of pneumonia, was not applicable for the Facility. The Monitoring Team recommends that the Facility ensure regular trends analysis, and administrative review of pneumonia at the Facility. <u>Management of seizure disorder</u> To assess the Facility's ability to clinically manage seizure disorder, the Monitoring Team reviewed the following documentation: • Alpha list of all individuals with diagnosed seizure disorder • Alpha list of all individuals who experienced an episode of status epilepticus during the reporting period • List of all individuals with diagnosis of intractable seizure disorder • List of all individuals with implantable VNS • For the first five individuals on the list of individuals with VNS, copy of the most recent VNS interrogation report • For all individuals diagnosed with intractable seizures. o Annual medical summary o Most recent two quarterly physician summaries o Most recent two neurology consultation reports o Current medication list o Most recent EEG o Most recent brain imaging report o Current six months medical provider's IPNs, specific for management of seizure disorder o IDT meeting minutes documenting supports and services necessary for the management of seizure disorder o Seizure log	

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		The Facility provided documentation stating that there were no examples of individuals with implantable VNS, experienced status epilepticus, or who were diagnosed to have intractable seizures. The Facility provided a data table that indicated 14 individuals being diagnosed with a seizure disorder, and provided documents for four out of five the examples requested by the Monitoring Team. The following is the Monitoring Team's summary of its document review of seizure management (Individuals #86, #118, #74, and #19): • Four out of four example (100%) included an accurate diagnosis for the seizure disorder. • Zero out of one example (0%) included a clinically appropriate medical action plan on the annual medical summary. The annual medical summary, including the medical action plan, did not comment on relevant issues related to seizure disorder, such as seizure frequency, efficacy of medication management, and necessary supports and services specific for seizure disorder. • Four out of four examples (100%) indicated that the Individual was regularly followed by neurology. • No individuals had a VNS device; therefore device interrogation measures were not assessed. It should be noted that two out of the four examples demonstrated clinical evidence of refractory seizure disorder (Individuals #19 and #86) and there was documentation indicating that these individuals would be assessed for possible VNS placement in the near future. The Monitoring Team will follow-up on the status of these two examples at the next compliance review. • Two out of four examples (50%) included IPNs by the medical providers indicating clinically appropriate medical follow-up, following reported seizure activity. • Two out of four examples (50%) had evidence indicating that an EEG was obtained within the past five years. • In zero out of four examples (0%), the ISP included information documenting the type of seizure disorder, risks and benefits associated with treatment, prognosis of the seizure disorder, efficacy of treatment, and all necessary supports and services required for the management of seizure disorder. • One out of four examples (25%) were treated with two or less anticonvulsants. The Monitoring Team is aware that some Individuals with intellectual disability, who have been treated for seizure disorder for many years, and who may have structural brain damage, may require significant polypharmacy to control seizure disorder; however, the annual medical assessment, and the ISP must reflect the need for polypharmacy, and indicate any attempts at reducing polypharmacy in the past.	

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		Summary: The Facility ensured that all individuals were followed closely by a neurologist, and that seizure disorder was diagnosed according to ICD criteria. The Facility should ensure that all seizure activity is evaluated by the medical provider; ensure that all individuals are assessed for VNS, when clinically necessary; ensure that the annual medical assessment documents a review of seizures during the past year, and include review of seizure log, and efficacy of treatment; and the ISP should include information documenting the type of seizure disorder, risks and benefits associated with treatment, prognosis of the seizure disorder, efficacy of treatment, and all necessary supports and services required for the management of seizure disorder. Conclusion: The Monitoring Team concurs with the Facility's findings of noncompliance with Section L.1. The Facility continued to demonstrate prompt and efficacious management of acute medical conditions, and effective documentation practices. The Facility must enhance its ability to address chronic care issues, such as seizure disorder, osteoporosis, cerebral palsy, and fractures, among others. The medical provider should ensure follow-up to all acute medical conditions through full resolution of the condition. The medical component of IDT meetings and the ISP must be enhanced, and the medical provider must ensure understanding of all known medical conditions, and convey all necessary supports and services needed to manage each medical condition to the IDT members.	
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 Monitoring Team also met with the clinical director to review the Facility's mortality review process. <u>External Medical Audits.</u> One medical provider was assessed through the external medical audit process that was conducted on May 23 – May 24, 2013. The external audit was conducted by a physician external to the Facility. The Facility provided "Analysis of Internal/External Medical Provider Audit: Round 7", for the time period August 2012 through April 2013, and a second set of audit reports titled "Analysis of Internal/External Medical Provider Audit: Round 7", for the time period February through April 2013. The Monitoring Team could not determine which medical providers were assessed, and given the dates indicated on the two sets of audit reports, was unable to determine which audit reports were specific for the May 2013	Noncompliance

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		audits. The requirements were divided into essential and nonessential elements. In order to obtain an acceptable rating, the Facility determined that essential items were required to be 100% in compliance; non-essential elements required a score of 80% or more compliance; and medical management elements required a score of 100%: The analysis provided for one practicing medical provider, at the time of the review indicated the following – note that all information provided regarding the analysis was devoid of identifying information: • A total of 12 records were reviewed. • The medical provider achieved a Facility determined passing score of 80% or more for non-essential elements. • The medical provider did not achieve a passing score of 100% for essential elements • The medical provider did not achieve Facility determined passing score of 100% or greater for medical elements, or the three medical management reviews o Diabetes had a cumulative score of 62%. o Osteoporosis had a cumulative score of 83%. o Pneumonia had a cumulative score of 82%. A total of 13 corrective action plans were developed at the time of this review, and three out of 13 (23%) were completed. The Monitoring Team discussed the process for the medical internal and external medical audits with the Facility's clinical director. The clinical director expressed the following deficits with the audit process: • The audits do not specifically identify work completed by the audited medical provider. For example, cross-covering medical providers may have addressed the clinical issues being assessed, and therefore the audit would be assessing the cross-covering medical provider, and not the intended medical provider. • The audit process reflects more of an administrative type of review, and not clinical competency. The Monitoring Team concurs with the clinical director's concerns with the audit process. The clinical director reported that in the past, he would meet with the medical providers that were audited and review the results, as well as incorporate audit results into annual performance evaluations; however, given that the medical providers that were reviewed for the past 12 months were no longer at the Facility, he was unable to discuss the results with the medical providers.	

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		Review of the medical management questions assessed for osteoporosis, diabetes, and pneumonia, indicated there were no examples of questions to determine if the medical provider assessed for the underlying etiology of a medical condition, or the efficacy of supports, and services prescribed to help mitigate exacerbation. There were no questions to determine if specific treatment modalities employed by the provider were the most current acceptable professional standard treatment for the medical condition. Summary: The current medical provider audit process does not assess clinical performance outcomes, and mostly assesses if the medical provider follows Facility procedures. The audit process should include a substantial component that assesses if the medical provider is practicing at the most current acceptable professional standard treatment for the medical condition, understands the etiology of diagnosed conditions, and if appropriate supports and services are efficacious. <u>Mortality review process</u> The Facility reported they had made no changes or revisions to their Administrative Death Review Committee, Policy: I.4.b and Clinical Death Review Committee, Policy: I.4.c since the last compliance review. Since the compliance review, one death had occurred on 10/5/13. The Administrative and Clinical Death Review Committees had been conducted and the death review process completed. The Monitoring Team met with the Facility's administrative and clinical staff and reviewed and discussed the death of Individual #40. The Monitoring Team also reviewed death review related documents and Individual #40's active record. The Monitoring Team's findings included: • Individual #40 was 22 years of age at the time of death. He was diagnosed with End Stage Renal Disease and was treated for Chronic Renal Failure for the last two years of life. He was referred to Hospice care for approximately the last month prior to death. The Hospice Nurse pronounced the death. The preliminary cause of to be determined by the Hospice Nurse provided was not available for review. According to the Facility's High Profile Incident Report, 10/5/13, the death was not due to unusual circumstances. No autopsy was conducted. A Do Not Resuscitate (DNR) order was in place at the time of death. The Monitoring Team's review of the death review related documents for compliance with the Facility's death review policies and processes found: • The Mortality Review Committee and Administrative Death Review Committee met timely and completed the death review according to Facility policy.	

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		The Monitoring Teams review of the specific mortality review indicated: • The mortality review committee did not assertively review the etiology of the contributing factors associated with the Individual's death, or if all reasonable treatment options had been entertained by the IDT. • Behavioral intervention strategies were not comprehensively reviewed by the committee. For example, the committee should have assessed if all behavioral interventions that may have better supported the Individual were considered by the IDT, and ethics committee; and determined if external consultation with behavioral experts should have been obtained. Summary: The Facility must enhance its mortality review process and ensure that the committee performs a comprehensive review of all contributing factors associated or possibly associated with deaths. It is essential that the committee have a comprehensive understanding of the underlying medical, and any related behavioral conditions associated with the cause of death, and determine if all reasonable interventions were considered by the IDT. Conclusion: The Facility must enhance its mortality review process by ensuring that the mortality review committee has a comprehensive understanding of the underlying medical, and any related behavioral, conditions associated with the cause of death, and determine if all reasonable interventions were considered by the IDT. The current medical provider audit process does not assess clinical performance outcomes, and mostly assesses if the medical provider follows Facility procedures. The audit process should include a substantial component that assesses if the medical provider is practicing at the most current acceptable professional standard treatment for the medical condition, understands the etiology of diagnosed conditions, and if appropriate supports, and services are efficacious. For these reasons, the Monitoring Team determined noncompliance with Section L.2.	
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;	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, round 7, occurred on 5/24/2013. One medical provider was assessed by the internal medical audit process: • The medical provider achieved a Facility determined passing score of 80% or	Noncompliance

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	identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	greater for non-essential elements • The medical provider did not achieve a Facility determined passing score of 100% for essential elements • The medical provider did not achieve a Facility determined passing score of 100% for medical management elements. • Of the 13 corrective actions developed for the medical audits, 10 out of 13 were completed by the time of this review. The Monitoring Team noted that only three medical management elements were assessed (pneumonia, osteoporosis and diabetes). Because the Facility utilized the same format, and same audit tools, as used by for the external medical reviews, the Monitoring Team has the same concerns, and recommendations. The reader is referred to external medical reviews, above in Section L.2 of this report, for the Monitoring Team's summary regarding the medical audit process. <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, but will be developing a process in the near future. Conclusion: The Monitoring Team noted that internal medical audits were conducted as scheduled, and that not all action plans developed for missed items were completed. As per Section L.2, of this report, the Monitoring Team has concern over the medical audit process's ability to assess clinical performance of the medical providers. 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. The Monitoring Team determined that the Facility is not in compliance with Section L.3.	
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	To assess if the Facility had all necessary policies and procedures in place to ensure that medical care is consistent with generally accepted professional standards of care, the Monitoring Team requested the policies and procedures associated with the provision of medical care, and discussed the Facility's progress in developing all necessary policies and procedures. The Facility did not have a policy and procedure book that delineated practice standards	Noncompliance

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	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.	for all components of medical care provided by the Facility. The Facility did provide a Standard Operating Procedure ICF-IID 400 14; Medical Care, dated November 2004, and revised July 2013. This procedure was comprehensive and incorporated many activities, such as documentation practices, writing orders, maintaining an active problem list, addressing acute medical conditions, and follow-up to chronic care issues, among many other relevant activities. The Monitoring Team determined that the RGSC Standard Operating Procedure was much more comprehensive then the updated DADS Medical Care policy that was previously reviewed by the Monitoring Team. Following review of the current RGSC Standard Operating Procedure for Medical Care, the Monitoring Team determined that the Facility was not adhering to its own procedure. For example, the procedure requires that the medical provider routinely monitor individuals for chronic health care conditions, and as noted in Section L.1 of this report, chronic care issues were not assertively monitored on a routine basis. Also, per review of consultation reports for Section L.1 of this report, when referring individuals for external consultation, the medical provider did not provide a clear synopsis of the medical problems, provide a pertinent past medical history, or provide pertinent laboratory data for review by the medical consultant. The Monitoring Team was also provided a Standard Operating Procedure ICF-IID 400 16 Premedication for Medical and Dental Procedures, dated November 2014, and revised October 2013. The policy appears to be clinically relevant. The Monitoring Team asked the clinical director if the Facility had reviewed and incorporated the DADS central office medical policy into practice at the Facility, and was informed by the clinical director that the Policy had not been adopted by the Facility, at the time of this review. Conclusion: The Facility continues to be noncompliant with Section L.4 because it has not developed or implemented essential policies and procedures to ensure that medical care is consistent with generally accepted professional standards of care.	

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: 11/6/13 2. RGSC Section M Action Plans, Updated: 11/5/13 3. RGSC Section M Presentation Book 4. 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. DADS SSLC Nursing Quality Assurance Audit Process, 3/21/13 7. DADS SSLC Nursing Protocol: Hospitalizations, Transfers and Discharges, March 2013 8. RGSC SOP NR400-27 Procedure for Post Hospital Assessment, June 2013 9. RGSC SOP MR 400 05, Guidelines for Management of Methicillin Resistant Staphylococcus Aureus (MRSA), April 2013 10. RGSC SOP ICF-IID-700 14, The Use of Restraint, June 2012 11. RGSC SOP NR200-34, Nursing Services Infection Control Objectives, May 2013 12. RGSC SOP NR200-33, Infection Control Admission Policy, May 2013 13. RGSC SOP NR200-79, Infection Control Admission Policy, May 2013 14. RGSC SOP NR200-400-12 Medication Variance Policy, January 2012 15. RGSC SOP ICF-IID 0-16, Premedication for Medical and Dental Procedures, October 2013 16. RGSC SOP ICF-IID-Anticoagulation Therapy Protocols, (approved July 2013) 17. RGSC SOP ICF-IID 400-16, Oral Suction Toothbrushing (approved August 2013) 18. RGSC SOP ICF-IID 400-18, Hospice Services (approved October 2013) 19. RGSC SOP NR 200-52, Deep Venous Thrombosis Assessment of Risk and Treatment (approved August 2013) 20. RGSC PNMP Nurse Post Hospitalization Assessment/Evaluation Form (approved May 2013) 21. RGSC Quality Assurance Plan, 10/16/13 22. RGSC Training Guidelines-Infection Control Prevention and practices, 11/10/11 23. RGSC Infection Control Prevention and Practices Workbook, 11/10/11 24. RGSC Percentage of staff vaccinated for Hepatitis B 25. RGSC Percentage of staff current with flu vaccinations 26. RGSC Percentages of staff current with Tuberculosis (TB) Skin Testing or other follow-up for those who have converted skin test 27. RGSC Percentage of individuals current with TB skin testing 28. RGSC Percentage of individuals current with the flu vaccinations 29. RGSC Medication Administration Observation Audit Summary 30. RGSC Medication Cart Exchange Process 31. RGSC Medication Error Process 32. RGSC Summary for Monthly Medication Variances, March 2013 through September 2013 33. RGSC Medication Error Investigation Reports for the last six months 34. DSHS-RGSC: "Reports of Medication Errors Filed", Crystal Reports, Printed 10/11/13 35. RGSC Completed Nursing Events Daily Logs for El Paisano and La Paloma, 11/11/13 through 11/18/13 36. RGSC MiniKardex Daily Reports for El Paisano and La Paloma, 11/3/13 through 11/18/13

	37. RGSC 2013-2014 At a Glance ICF-IDD Nurse Refresher Training Schedule 38. RGSC 2013-2014 Nurse Education and Training Database 39. RGSC Kangaroo Joey Enteral Pump Operation Training Rosters 40. RGSC New Employee Orientation Agenda 41. RGSC Nursing Orientation Book 42. RGSC List of Nursing Staff by Areas of Responsibility 43. RGSC ICF Nursing Services Employee Staffing Analysis by shift, March 2013 through September 2013 44. RGSC Nursing Staffing Overtime and Contract Hours by shift for September 2013 45. RGSC Monthly Nursing Minimum Staffing for Homes, by shift April 2013 through September 2013 46. RGSC Qualified Intellectual Disability Professionals and RN Case Managers Caseloads 47. RGSC Schedule of meetings requiring nursing participation during the week of the visit 48. RGSC Daily Morning Medical Report Minutes, 11/11/13 through 11/21/13 49. RGSC Daily Morning Medical Report Sign-in Sheets, 11/11/13 through 11/21/13 50. RGSC Daily Nursing Morning Medical Reports by Shift for El Paisano and La Paloma, 11/11/13 through 11/21/13 51. RGSC Completed Nursing Referrals Presented at the Morning Medical Reports, 11/11/13 through 11/21/13 52. RGSC CATW2 Weekly Appointment Schedules Reviewed by Medical Hospital Liaison and RN Case Managers and Accompanying Individual Appointment Schedules, April 2013 through October 2013 53. RGSC List of Section M Key Indicators 54. RGSC 24 Hour Chart Check Review of Orders Form 55. RGSC Nursing Floor Checklist by Shift Forms 56. RGSC Physical Nutritional Management Team Committee Meeting Minutes and Sign-in Sheets, 10/1/13 through 11/12/13 57. RGSC Monthly ICF-MR Nursing Meeting Minutes, April 2013 through September 2013 58. RGSC Performance Improvement Report, In-Patient Pharmacy – FY2013 (June 2013, July 2013, and August 2013) 4th Quarter 59. RGSC Infection Control Surveillance Checklist, May 2013 and June 2013, 60. RGSC Antibiotic Therapy Monitoring – Q3FY2013 and Q4FY2013 61. RGSC Safety/Risk Management/Infection Control Committee Minutes, 4/11/13, 5/9/13, and 6/27/13 62. RGSC Infection Control Report Q3FY2013 63. RGSC List of Location for Automated External Defibrillators and Emergency Equipment 64. RGSC List of Staff Responsible for Conducting Mock Medical Emergency Drills 65. RGSC Emergency Response and Equipment Training Material 66. RGSC All Hazards Plan, 8/20/13 67. RGSC Completed Emergency Drill Checklists, April 2013 through September 2013 68. RGSC Completed Emergency Equipment Walkthrough Checklists, April 2013 through September 2013 69. RGSC Copy of Blank Section M – Nursing Monitoring Tool Forms and Instructions 70. RGSC Annual Nursing Assessment Audit Process for Timeliness of Completion 71. RGSC Assessment Calendar for RN Case Managers 72. RGSC Acute Care Plan Process and Implementation Instructions 73. RGSC Medication Investigation Summary Reports, 4/11/13 through 9/30/13

	74. RGSC Reports of Medication Errors Filed, 9/11/12 to 9/11/13 75. RGSC New Medication Cart Audit Process 76. RGSC Drug Storage/Sanitation (Internal and External Separation of Medications), Drug Expiration Dates, Expired Medications, Removal of Worn Out Illegible Labels, and Adaptive Devices (Eye Glasses) Forms for the 6-2 Shift and 2-10 Shift 77. RGSC Medication Administration Observation Data Summary, March 2013 through August 2013 78. RGSC Monthly Refrigerator/Freezer Cleaning Logs for El Paisano and La Paloma, 1/1/13 through 11/20/13 79. RGSC Pharmacy and Therapeutics Sub-Committee Meeting Minutes, 5/15/13 and 6/26/13 80. RGSC Pharmacy and Therapeutic Sub-Committee Meeting Minutes Agenda, 10/17/13 81. RGSC Medication Management Workgroup Notes, 4/8/13 and 7/23/13 82. RGSC Restraint Training Summary and Training Rosters, January 2013 through August 2013 83. RGSC Physical Nutritional Management Monitoring Report for Medication Administration Observations, 8/5/13 through 11/8/13 84. Sample of Nursing Discharge Summaries and Community Living Discharge Plan Packets for Individuals: #62, #47, and #75 85. Sample of Direct Care Professionals' Instruction Sheets for Individuals: #145, #149, #35, #133, #3, #82, #127, #139, #76, and #46 86. Sample of the last reported infections for Individuals: #61, #133, #5, #98, and #15 87. Sample of recent emergency room visit for Individual #46 **People Interviewed:** 1. Anne Menz, RN, BSN, MSN, PhD, Chief Nurse Executive (CNE) 2. Belinda Portales, RN, Quality Enhancement (QE) Nurse 3. Robin Martin, RN BSN, MSN, Nursing Operations Officer (NOO) 4. Hilaree Mariboa, RN, Unit Nurse Manager 5. Jamie Rodriguez, RN, RN Case Manager 6. Roger Garza, Jr. RN, Supervisor (contract RN) 7. Lorraine Hinrichs, IFC-IID Program Director 8. Numerous Staff Nurses and Direct Care Professionals **Meeting Attended/Observations:** 1. Review of Section M Presentation Book with Nursing Operations Officer, Unit Nurse Manager, Nurse Educator, and Quality Enhancement Nurse, 11/18/13 2. Medication Administration Observations, 11/18/13 and 11/20/13 3. Morning Medical Report, 11/19/13 and 11/20/13 4. Physical Nutritional and Management Team (PNMT) Committee Meeting, 11/19/13 5. Annual ISP Meeting for Individual #84, 11/19/13 6. ISPA Meeting for Individual #46 7. 30 Day ISP Meeting for Individual #28, 11/21/13 8. Settlement Agreement Program Improvement Council (SA-PIC) Meeting, 11/21/13 9. Meeting with CNE, 11/21/13 10. Numerous tours in La Paloma and El Paisano throughout the compliance visit

	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 Assessment of Timeliness Tool Audits, Infection Control data, Mock Medical Drill Audits, and Medication Administration Observation and Medication Variance 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, and record reviews to determine status of compliance with the respective monitoring processes. ▪ The Self-Assessment identified the sample(s) sizes, including the number of records reviewed. The sample sizes were not 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 month, quarter, and overall percentage of compliance. ▪ 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 Nursing Operations Officer, Quality Enhancement Nurse and Unit Nurse Manager. ▪ An inter-rater reliability process had not been established between the various Facility staff responsible for the completion of the tools. ▪ 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. ▪ The Facility presented data but it was not consistently analyzed and trended in a meaningful and useful way, although the sample sizes were limited. 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 Did not measure the quality of items. o Distinguished data collected by the QA Department versus the Nursing Department. The Action 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. The Facility's Self-Assessment stated they were not in compliance with Provisions M.1, M.2, M.3, M.4, M.5 and M.6. The Monitoring Team concurred with their findings. None of the provisions were found in substantial compliance.
	Summary of Monitor's Assessment: The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for all

	provisions of this Section, because the Facility had made limited progress. The noncompliance findings from the last review stand. The areas that had made the most progress were recently formalized processes for making nursing referrals to present at the Morning Medical Report meetings and improvements made in the 24 Hour Nursing Log. Several internal nursing monitoring tools were streamlined into more meaningful and useful tools for management. Improvements were made in medication management processes. The areas of least improvement were found in the timeliness and quality of the nursing assessments and in development and implementation of individualized acute care plans. Provision M.1: The Nursing Department was fully staffed with a Chief Nurse Executive, Nursing Operations Officer, Unit Nurse Manager, and Nurse Educator. The Facility had made several improvements in the day to day management of the nursing operation. The Facility continued to conduct and to expand the integrated participation of staff attending Morning Medical Report meetings. There was lack of data presented for the Nursing Monitoring Tools and Nursing Protocol Audit Tools. The inter-rater reliability process was not in place. There was a continuing deficit in assessing and documenting acute illness and injuries, particularly infections. The Infection Control Preventionist continued to maintain the requirements for infection control. However, the monthly Safety/Risk Management/Infection Control Committee minutes for the last four months were not provided for review as requested. The Emergency Response System continued to follow policy requirements. The Facility Self-Assessment stated they were not in substantial compliance with this Provision and the Monitoring Team concurs. Provision M.2: The Nursing Department had four RN Case Managers which reduced the average caseload ratio to approximately 1 to 16 individuals per caseload. However, the Annual/Quarterly Nursing Assessment showed no appreciable improvement in timeliness, content, and quality. It is essential that nursing administration urgently make improvements in this area of performance in order to move forward toward compliance with this Provision. The Facility Self-Assessment stated they were not in substantial compliance with this Provision and the Monitoring Team concurs. Provision M.3: As was found in past reviews, the IRRF and IHCP processes were still evolving. Consequently the IHCP Action Steps were also evolving and needs to contain more in-depth interventions sufficient to meet individuals' health care needs. The Facility needs to ensure that all individuals' IHCPs that require Direct Care Professional Instruction Sheets are completed and placed in their "Me Book" for ready access by the direct care professional. The Acute Care Plans need to be more individualized and to incorporate relevant nursing protocols. All care plans should show documentation that they were carried out according to the plans and followed through to resolution. As more training is provided and experienced is gained on completing the IRRFs and IHCPS by the IDTs and the respective disciplines in developing and implementing these processes, continued improvements should be made in the content of the clinical data and quality of these processes. The Facility's Self-Assessment stated they were not in substantial compliance with this Provision and the Monitoring Team concurs. Provision M.4: It was positive to find that a full time Nurse Educator was hired since the last compliance

	review. In the short time since she had been hired she had begun to make significant improvements in the development and implementation of centralized systems for tracking all nursing training. The Nursing Educator was using the state competency-based Nursing Education Hand Book for New Nurse Orientation and annual refresher training. A formalized schedule was developed for each week of the month. The Nurse Educator was reinforcing training on the nursing assessments and documentation, 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 Facility Self-Assessment stated they were not in substantial compliance with this Provision and the Monitoring Team concurs. Provision M.5: As was found in past reviews, the IRRF and IHCP processes were evolving. As more training is provided and experienced is gained by the IDTs and the respective disciplines in developing and implementing these processes, continued improvements should be made in the content of the clinical data and quality of these processes. There continued to be variation in the content and quality of IRRFs and IHCPs completed by different IDTs. It is essential that the IDTs and respective disciplines consider the interrelationship of risk factors within a category and between categories when determining risk ratings. The Facility Self-Assessment stated they were not in substantial compliance with this Provision and the Monitoring Team concurs. Provision M.6: Since the last compliance review the Facility made significant improvement in numerous medication management processes. In La Paloma two separate areas were created from which to administer medications. Each area had Medication Record Notebook and medication cart. This reduced the number of individuals receiving medication to an approximate 1 to 16 ratio. Two nurses administered medications simultaneously. This method reduced the time it took to administer medication and reduced distractions. El Paisano planned to have two areas to administer medication in December 2013. Medication cart exchanges were conducted in the pharmacy. This improved the efficiency and accuracy of the exchange, enhanced the ability to reconcile medications, and reduced distractions. There were improvements in Medication Administration Observations, Medication Room Audits, and Medication Administration Record Audits. The Medication Management Workgroup Committee and Pharmacy and Therapeutics Committee minutes for the last four months were not provided for review. 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. All medication variances committed by the responsible disciplines must be reported and corrective action provided when necessary. The Facility needs to ensure that medication variance data are clearly separated from Mental Health data. The Facility Self-Assessment stated they were not in substantial compliance with this Provision and the Monitoring Team concurs.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with	The Facility requested reduced monitoring due to history of compliance ratings and/or areas impacting individuals' health or safety, but in which little progress has been made	Noncompliance

#	Provision	Assessment of Status	Compliance
	full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	for areas in noncompliance during previous compliance reviews. For Provisions M.1 through M.6, due to recent initiatives implemented the Facility requested the submission of a reduced sample of their choosing for the Monitoring Team to provide feedback on, which included a review of the medication error/variance review process, Integrated Risk Rating Forms (IRRFs), Integrated Health Care Plans (IHCPs), MOSES/DISCUS for quality, and a sample size of two records per RN Case Manager for a total review of eight records. Refer to Section J for a review of the quality for MOSES/DISCUS. <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 Presentation Book, review of active records, and documents requested. Conducted interviews with the Chief Nurse Executive, Nursing Operations Officer, Unit Nurse Manager, Nurse Educator, and QE Nurse. 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, mock medical emergency drills, and the emergency response system. Additional information regarding the nursing assessment, development, and implementation of health care plans is found below in Provisions M.2, M.3, and M.5 of the report. Information and recommendations regarding nursing documentation on restraint usage and death review is included above in Provisions C.5 and L.2 of the report. The Monitoring Team conducted a reduced review of the items included in this Provision to determine continued progress and/or to identify additional areas of progress and/or regression. <u>Staffing</u> At the time of the compliance review the Facility census was 65. It was positive to find that the four administrative/leadership Registered Nurse (RN) positions were filled, which included the Chief Nurse Executive, Nursing Operation Officer, Unit Nurse Manager, and Nurse Educator. It was evident thorough interview and review of documents 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 Nursing Department should now have sufficient administrative and management staff, provided there is retention of the recently hired staff. The CNE position was not included as a nursing position. Two RN nursing positions were not counted in the nursing services' staffing. One RN served as the Quality Enhancement Nurse and the other served as the Physical Nutritional	

#	Provision	Assessment of Status	Compliance
		Management Team (PNMT) Nurse. The PNMT Nurse no longer served as the Hospital Liaison Nurse. This responsibility was assumed by the RN Case Managers. The Infection Control Preventionist was responsible for the Infection Control Programs for the Intermediate Care Facility, Mental Health Hospital, and Out Patient Clinic and was not counted as part of nursing services' staffing. The four RN Case Manager positions were filled, but one RN Case Manager was in the process of resigning. It is essential once the RN Case Manager position is vacant that it is filled as soon as possible. The four RN Case Managers should be sufficient to case manage 65 individuals' health care needs, based on average caseload ratio of approximately 1:16 individuals. Individuals who reside in La Paloma were more medically fragile, while individuals who reside in El Paisano had more behavioral issues. The Nursing Department had a total of 11 nursing floor staff, of which four were RNs and seven were Licensed Vocational Nurses (LVNs) with one vacant LVN Position. The two unit clerical positions were filled. RN and/or LVN agency nurses continued to be used to supplement vacancies and fill in for staffing shortages. Most of the agency nurses had worked at the Facility for some time and were familiar with the individuals and nursing services' routines. At the last compliance review, the Nursing Operations Officer reported he 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 addition of these nursing positions would be a positive step forward and should further strengthen nursing services' ability to provide health care services. At the time of this compliance review, the Nursing Operations Officer reported the contract had been approved but no further action had been taken. The Monitoring Team's review of the nursing staffing analysis, by month, by home, and by shift, April 2013 through September 2013, showed none of the shifts had fallen below the established minimum staffing ratios. This continued to be a positive finding considering the limited number of staff nursing positions available, including agency nurses. <u>Quality Enhancement Efforts:</u> The Monitoring Team conducted a reduced review of Quality Enhancement Activities and found: • While reviewing the Section M Action Plans, the Nursing Operations Officer was asked about nursing's quality assurance audit process and was told they did not have a process. However, copies of DADS SSLC Nursing Quality Assurance Audit Process and RGSC Quality Assurance Plan were provided later.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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The Nursing Operations Officer was responsible for overseeing the monitoring process and for generating reports. The Nursing Operations Officer was responsible for interpreting and analyzing the data. The Facility's Settlement Agreement-Program Improvement Council (SA-PIC) reviewed the audit results. The expectation was 90% compliance with the tools. Tools falling below 90% required the initiation of corrective action plans. SA-PIC monitored the corrective action plans, modified plans the when indicated, and followed the plans through to resolution.
The Nursing Monitoring Tools and Protocol Audit Tools selected for audits included the Aspiration Protocol Audit Tool, Constipation Protocol Audit Tool, Infection Control Nursing Monitoring Tool, Nursing Care Nursing Monitor, and Annual/Quarterly Monitoring Tool. There were no data provided on these audit/monitoring tools, with the exception of Annual Nursing Assessments audited. However, only the timeliness of completing the Annual Nursing Assessment was measured. The process did not include how or who conducted inter-rater reliability checks. Neither was inter-rater reliability data included for the Annual Nursing Assessment audits.
According to the Self-Assessment there were two RN Case Managers for each unit. The caseloads were divided and each RN Case Manager was supposed to audit their partner's caseload. Each RN Case Manager was to audit one Annual Nursing Assessment per month for a total of four Annual Nursing Assessments audited. The Facility's Self-Assessment Report of Annual Nursing Assessments for timeliness of completion and monthly authentication for the past six months showed:

<table>
<tr><th>Month/Year</th><th>Percentage of Compliance</th></tr>
<tr><td>April 2013</td><td>0%</td></tr>
<tr><td>May 2013</td><td>20%</td></tr>
<tr><td>June 2013</td><td>25%</td></tr>
<tr><td>July 2013</td><td>20%</td></tr>
<tr><td>August 2013</td><td>25%</td></tr>
<tr><td>September 2013</td><td>100%</td></tr>
</table>
The Monitoring Team's review of the audit data showed that four Nursing Annual Assessment audits were not consistently completed monthly making the accuracy of the data questionable. The data provided in the Self-Assessment for the number of audits completed by the RN Case Managers for each unit is shown in the chart below:
<table>
<tr><th colspan="4">Monthly Monitoring Tools Submitted by Case Manager</th></tr>
<tr><td>Month/Year</td><td>Score</td><td>La Paloma</td><td>El Paisano</td></tr>
<tr><td>April 2013</td><td>100%</td><td>2</td><td>2</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance

May 2013	75%	2	1
June 2013	50%	0	2
July 2013	25%	1	0
August 2013	75%	1	2
September 2013	25%	1	0

The Facility's plan of correction was for the RN Case Managers to have clerical support and more organization. The outcome of the plan of correction was not provided for review.

- The Monitoring Team attended the SA-PIC Meeting on 11/21/13. The discussion and review of the documents provided at the meeting showed two open Corrective Action Plans (CAPs) for nursing. They were related to individual employees as opposed to addressing systemic issues. One CAP was initiated on 11/20/13 by the Incident Management Review Team related to RN Case Manager's failure to perform a full body assessment on 11/1/13 for an allegation of physical abuse on an individual. The recommendation was for the Nurse Educator to train the nurses and RN Case Managers on proper procedures to follow for instances of Abuse, Neglect, and Exploitation and for Unusual Incident Reports. The expected due date for closure was 12/4/13. The other CAP was initiated on 11/14/13 by SA-PIC due to a CAP Ineffectiveness Audit. It was recommended that the Nursing Referral Form be changed to include a space to document where individuals were assessed for falls and to train Professional Nursing Assistants (PNAs) and nurses on how to properly document falls. Expected due date for closure was 12/14/13. There was no data provided at the meeting regarding the selected Nursing Monitoring Tools and Protocol Audit Tools.
- The Nursing Department continued to conduct additional audits as were reported in the previous compliance review that were primarily related to Section M Key Indicators. Relevant data from these audits are reported in the respective Provisions of the report.

As was found at the last compliance review, the Nursing Department's efforts for completing quality enhancement activities showed no appreciable improvement. There was no data available for review on the Nursing Monitoring Tools and Protocol Audit Tools, with the exception for Annual Nursing Assessments. Therefore, progress toward compliance with monitoring/audit tools could not be determined. The Nursing Department should ensure that all Nursing Care Monitoring Tools and Protocol 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 $CATW_2$ should be developed, implemented, and followed through to resolution. The Quality Enhancement Department needs to enhance

#	Provision	Assessment of Status	Compliance
		inter-rater reliability checks on all nursing monitoring and audit tools, as well as Medication Observations. The Monitoring Team suggests conducting a full review of nursing's quality enhancement efforts at the next compliance review. <u>Assessment and Documentation of Individuals with Acute Changes in Status:</u> Areas that showed improvement since the last compliance review included: • The Monitoring Team attended the Morning Medical Report meeting on 11/19/13, and 11/20/13. The Facility had continued to conduct and to expand the integrated participation of staff attending the meetings. According the Facility's Self-Assessment their new process for the Morning Medical Reports was driven by a specific agenda to review all changes in health care status of individuals with the Medical Doctor. The meeting was conducted each business day at 8:00 a.m. The meetings included 100% review of all Nursing Referrals generated from the previous business day. Copies of all referrals were brought to the meetings for discussion. The Hospital Liaison Clerk sent out daily email notification of 24 hour reports, Nursing Referrals, Physician Order's, any consultations ordered, and Aspiration Trigger Sheets. Disciplines participating in the meetings included: The Clinic RN who chaired the meeting, Medical Doctor, RN Case Managers, QIDP staff, Habilitation Therapy staff, QE Nurse, Speech Therapist, Psychology staff, Chief Nurse Executive, Nursing Operation Officer, Unit Nurse Manager or designee, Psychiatrist, CNE, NOO, QE Nurse, PNMT Nurse, Unit RN Case Managers, Clinic Nurse, QDDP Supervisor, Unit QDDPs, Speech Therapist, and Hospital Liaison Clerk who served as a scribe. On Mondays the PNMT Director attended the meeting to report and discuss any cases of aspiration pneumonia and/or other related high risk conditions. On Tuesdays weekly consultations were reported and discussed. On Wednesdays nursing reported and discussed skin integrity issues. On Thursdays the Infection Control Preventionist reported and discussed infections. On Fridays consultation results were reported and discussed, along with in-services provided by the physicians and/or psychiatrist. 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	

#	Provision	Assessment of Status	Compliance
		from the morning medical team members and disciplines. • Since the last compliance review, the Unit Nurse Manager had made several improvements in reporting documents related to health care follow-up, which included: o The Nursing Events Daily Log had been updated to include more pertinent information to report shift to shift for follow-up. o A Nursing Morning Medical Report Form was developed and implemented for the nursing staff to complete by shift and by unit on acute and chronic medical issues to present at the Morning Medical Reports. Reporting items included: Hospitalization, Emergency Room Visit, and acute care plans; On Call Medical Doctor (MD) notifications and orders; restraints – chemical and/or physical; medication refusals; MD changes in line of supervision (LOS) for medical support; sick calls; nursing referrals to MD, and antibiotic therapy. o A formalized Nursing Referral Form was used to make referrals to the physicians and interdisciplinary teams (IDTs) regarding incidents/injuries, illness, and seizure activity generated the previous business day and presented at the next Morning Medical Meeting. The nursing staff consistently completed the Nursing Morning Reports and Nursing Referral Forms. The Monitoring Team attempted to cross-check the Morning Medical Reports with the Nursing Morning Medical Reports and Nursing Referrals for the period of 11/18/13 through 11/18/13; however, every other page of the Morning Medical Reports was not copied. Therefore, the accuracy of the cross-check could not be determined. The limited review of the Morning Medical Reports and Monitoring Team's attendance at the Morning Medical Report meetings did not find that actions for follow-up on relevant items were consistently included. Nor did it appear there was consistent follow-up when indicated from previous reports. • The Hospital Liaison Clerk continued to maintain a robust Appointment and Tracking Database to not only schedule clinic and consult appointments but also to reschedule missed appointments. It also functioned to capture and retain individuals' historical data regarding dates and types of past appointments/consults. Daily appointment schedules and reports were 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 review April 2013 through September 2013. The reasons for the failure to keep the appointments were documented and a CATW2 was completed for the missed appointments when indicated. • The Nursing Department continued to implement the process for assessing five individuals on each shift who needed nursing assessments per the morning reports.	

#	Provision	Assessment of Status	Compliance
		The Monitoring Team was provided copies of the Minikardex 11/3/13 through 11/18/13 to review and validate the process. 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 assessments per the morning report were assessed for: Vital Signs and oxygen saturation levels and when indicated focus assessments were completed for specific conditions, to the respective nursing protocol card. 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. This process showed improvement from the previous compliance review. o The Nursing Department had continued to consistently perform and document 24 Hour Checks on Physician Order's. These checks were verified though review of records for Individuals: #36, #4, #126, #150, #145, #48, #65, and #139. Areas that did not show appreciable improvement since the last compliance review included assessments of individuals with acute changes in status. 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 active records for Individuals: #36, #4, #126, #150, #145, #48, #65, and #139, 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 complete and appropriate nursing assessments in individuals' response to presenting signs and symptoms of changes in status; and/or changes in vital signs and oxygen saturation measurements, including consistent lung and/or bowel sound assessments for respiratory and gastrointestinal issues. • 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.	

#	Provision	Assessment of Status	Compliance
		• 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 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. <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, particularly since other relevant discipline documentation were not included to review that would have demonstrated integration of services. • Integrated Progress Notes were not consistently documented in the Subjective, Objective, Assessment and Plan (SOAP) format when indicated for assessment related clinical data. • As was found in previous reviews, the Facility Direct Care Professional Instruction Sheets related to the Integrated Health Care Plans were not consistently in the "Me Books" for the individuals' records reviewed. • Numerous records/documents requested onsite and offsite were missing and/or were missing pages within documents for offsite review. • One Nursing Assessment was not in the active record at the time of the review, but was located and provided in records copied and sent for offsite review. <u>Hospital Liaison Nurse Activities:</u>	

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		Since the last compliance review, the PNMT Nurse no longer serves as the Hospital Liaison. This responsibility has shifted to the RN Case Managers. None of the eight individuals' whose records were selected by the Facility had been hospitalized recently. However, Individual #46 who was diagnosed with pulmonary fibrosis experienced a sudden episode of acute respiratory distress in the day room that was observed by the Monitoring Team's physician. The nurse was requested to come and assess Individual #46 and for staff to bring a wheelchair. Prior to the nurse's arrival Individual #46 coughed out a mucous that appeared to relieve the acute episode of respiratory distress. A review of the nursing assessment found that the assessment completed did not follow the Respiratory Distress Protocol. This was discussed with the Nursing Operations Officer. Later in the afternoon an ISP Addendum (ISPA) meeting was conducted. All relevant disciplines attended and discussed Individual #46's respiratory health history, current treatments, and recent consults with the pulmonologist and sleep studies, as well as for potential plans for managing his condition. Afterwards the physician decided to send Individual #46 to the emergency room for further evaluation and treatment. Prior to sending Individual #46 to the hospital the nurse completed neither a pre-hospital head to toe nor a focus respiratory system assessment as required per Hospitalization, Emergency Room Visit and Transfer Protocol/Policy. However, the Transfer Form was completed and sent with Individual #46 to the emergency room. There was documentation in the Integrated Progress Notes for the time Individual #46 left the Facility via Facility van, accompanied by one to one staff, and nurse to nurse contact made with the emergency room. Upon return from the emergency room the same day, a Post-Hospital/ER/LTAC Nursing Assessment was completed as required. Individual #46 was diagnosed and treated for viral respiratory illness with wheezing. Individual #46 was prescribed Prednisone 20 mg orally, two tablets once a day for five days. After the post-hospital assessment was completed there was no further documentation in the Integrated Progress Notes showing that the Respiratory Distress Protocol was followed or documentation for the therapeutic response to the Prednisone. The next note reported Individual #46 coughed one time while eating and three times after eating. The nursing assessment was limited to a set of vital signs and oxygen saturation level. No respiratory/lung assessment was completed. The note stated he would be seen by the physician and a telephone message was left for the PNMT staff. No further Integrated Progress Notes were provided for review. Refer to Section L for more information on Individual #46's condition and medical management. The following is the Monitoring Team's assessment of the Facility's ability to manage acute hospitalizations for individuals #65, #150, #40, #108, and #61: • Four out of five examples (80%) included a comprehensive hospital transfer note, completed by the nurse. The Monitoring Team was, however, concerned that a copy of the actual transfer note was not provided for review, and only a copy of the electronic record documenting what the nurse reported to the acute care hospital	

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was provided as part of this document request. Subsequent compliance visit will require that a copy of the actual transfer note be provided for review.

- Five out of five examples (100%) included comprehensive nurse liaison notes, documenting the complete hospital stay.
- One out of five examples (20%) included a comprehensive nurse liaison post hospital discharge note.

Infection Control Activities

The Monitoring Team's review of the documents requested and reviewed showed, as was found in the last compliance review that the Infection Control Preventionist (ICP) continued to maintain the positive Infection Control practices. The following exceptions were found:

A review of the Facility's Self-Assessment data for reporting infections to the ICP and the Antibiotic Therapy Monitoring Reports for September 2012 through July 2013 showed regression as indicated in the chart below:

Month/Year	Notification of and documentation of notification in the Integrated Progress Notes	Daily documentation of evaluation of problem/antibiotic therapy until resolution	Completion of Acute Care Plans
September 2012	65%	34%	0%
October 2012	48%	13%	13%
November 2012	27%	4%	17%
December 2012	45%	0%	33%
January 2013	41%	14%	0%
February 2013	34%	0%	0%
March 2013	19%	7%	0%
April 2013	33%	11%	0%
May 2013	10%	23%	13%
June 2013	33%	0%	0%
July 2013	33%	50%	17%
August 2013	50%	34%	0%

There was documentation that the ICP reported the above data to nursing administration. There was no documentation provided to indicate that corrective action plans were developed and implemented to improve reporting infections and antibiotic therapy use, documentation in the Integrated Progress Notes regarding the evaluation of the infections and therapeutic response to antibiotic therapy through to resolution, and

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		the implementation of Acute Care Plans (ACPs). It is essential that nursing administration address this issue. Refer to Provision M.3 for a report on individuals' ACPs who had infections. The Safety/Risk Management/Infection Control Committee Minutes provided to review over the last six months were for 5/9/13 and 6/27/13. Therefore, it was not possible to determine the current status of the required reporting measures. <u>Skin Integrity Activities</u> Since the last compliance review, Skin Integrity issues were reviewed and discussed in the PNMT Committee meeting. The Monitoring Team attended the PNMT Committee on 11/19/13. The Nursing Operation Officer reported on skin integrity issues. Individuals #126 and #15, who had previous Stage two pressure ulcers were healed. No pressures ulcers were reported for the last quarter. <u>Medical Emergency Response Activities:</u> Since the Facility requested a reduced review, only limited review and feedback is reported for the Medical Emergency Response Activities, with the exception of reporting that the Mock Medical Drills in the Safety/Risk Management/Infection Control Committee minutes were only provided for 4/11/13, 5/9/13, and 6/27/13. Therefore, it could not be determined if Mock Medical Drills were reported monthly as required. According to the Facility's Self-Assessment data and emergency response documentation provided for review, Mock Medical Emergency Drills were conducted as required and emergency equipment was checked daily and then analyzed monthly as shown in the chart below: Mock Drill Monthly Passing Rate No. of Pass / No. of Drills / Score 5 / 5 / 100% 4 / 4 / 100% 6 / 6 / 100% 3 / 4 / 75% 7 / 7 / 100% 4 / 4 / 100% In the month of 07/2013, three out of four drills passed and one failed due to a new agency nurse who was not familiar with the protocol. The nurse was counseled by administration and trained by NOO. The nurse verbalized understanding. Emergency Medical Checklist	

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Home #1	Home #2	Score
100%	100%	97%
97%	100%	99%
100%	100%	100%
87%	90%	95%
97%	97%	97%
97%	97%	98%

The positive practices identified in the report should be maintained and improvements made in other areas of practice in order to achieve substantial compliance. Based on the Monitoring Team's independent review and the Facility's Self-Assessment, this Provision was not found in substantial compliance.

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M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. <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 Section M Presentation Book; review of active records and documents requested; conducting interviews with the Chief Nurse Executive, Nursing Operations Officer, Unit Nurse Manager, Nurse Educator, and QE Nurse, and attendance at ISP and ISPA Meetings. 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. Due to the Facility's request for a reduced review, the feedback on nursing assessments is limited. <u>Policies, Procedures, Processes, and Protocols:</u> Since the last compliance review, there were no new policies, procedures, processes and/or protocols. <u>Training Activities:</u> Since the last compliance review, there was no documentation that additional training was provided for this Provision.	Noncompliance

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		The status of the mandated Physical Assessment and Documentation Class, RN to RN Check-off, and Mosby Chapter review for RN Case Managers and RNs was not provided for review. This training was discussed with the Nurse Educator who stated she planned to conduct refresher training on this class. The status of this training will be reviewed at the next compliance review. <u>Timeliness of Assessments</u> According to the Self-Assessment there were two RN Case Managers for each unit. The caseloads were divided and each RN Case Manager was supposed to audit their partner's caseload. Each RN Case Manager was to audit one Annual Nursing Assessment per month for a total of four Annual Nursing Assessments audited. The Monitoring Team's review of the audit data showed that four Nursing Annual Assessment audits were not consistently completed monthly making the accuracy of the data questionable. Each RN Case Manager was scheduled to conduct one Nursing Annual Assessment per month of their RN Case Manager partner, for a total of two audits per unit per month. The data provided in the Self-Assessment for the number of audits completed by the RN Case Managers for each unit is shown in the chart below:	

Monthly Monitoring Tools Submitted by Case Manager

Month/Year	Score	LP	EP
April 2013	100%	2	2
May 2013	75%	2	1
June 2013	50%	0	2
July 2013	25%	1	0
August 2013	75%	1	2
September 2013	25%	1	0

The data above only addressed the timeliness of completion of the Nursing Assessments. The data as compared to the last compliance review showed regression in the timeliness for completion of the nursing assessment, for September 2013. The Facility's plan of correction was for the RN Case Managers to have clerical support and more organization. The outcome of the plan of correction was not provided for review.

The Nursing Department continued to have four RN Case Manager positions. It was of concern that nursing assessments were not completed timely considering there was approximately a 1 to 16 ratio of individuals per RN Case Manager. The RN Case Managers were paired with Qualified Intellectual Disability Professionals (QIDPs) who

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		had the same caseloads and were physically located in the same office. This should enhance the ease of communication between the two disciplines. In addition, the RN Case Managers were required to attend and participate at the Morning Medical Meetings and present Nursing Referrals. However, a limited review of Morning Medical Report meetings minutes and Nursing Referrals from 11/11/13 through 11/21/13, along with the Monitoring Team's attendance at the Morning Medical Report meetings 11/19/13 and 11/20/13, did not find that the RN Case Managers consistently performed these functions. The Monitoring Team's observations of the RN Case Managers' performance appeared to be less than satisfactory and was discussed with the Chief Nurse Executive Nurse and Nursing Operations Officer. The Monitoring Team reviewed two records from each of the four RN Case Managers selected by the Facility's choosing. The most recent Comprehensive Annual/Quarterly Nursing Assessments were reviewed for Individuals #36, #4, #126, #150, #145, #48, #65, and #139. A review of the Annual and Quarterly Nursing Assessments for timeliness, content, and quality found no improvement from the last compliance review. Finding included: • One of one (100%) Admission Comprehensive Nursing Assessment was completed within 30 days of admission. • Zero of three (0%) Annual Comprehensive Nursing Assessments that were due were completed on time, according to Facility policy. • One of four (25%) Quarterly Comprehensive Nursing Assessments due was completed on time, according to Facility policy. • Of the eight records provided for review the following nursing assessment information was missing: o Individual #150 was missing the first Quarter Nursing Record Review and Physical Assessment. The last nursing assessment provided for review was for third quarter, and completed on 4/17/13. o Individual #139 was missing the second page of the third Quarter Nursing Record Review and the second page of the accompanying Physical Assessment Record. o While conducting an onsite record review for Individual #65 the Admission Comprehensive Nursing Assessment was not in the active record. However, the QE Nurse found the assessment and it was included in the records provided for the offsite review. Due to the missing most recent nursing assessments for Individual #150 and Individual #139, those records were not included in the overall review because it was not possible to determine the current health status of these individuals in relation to their high/medium risk ratings and health care services and supports provided. When records requested are not provided for review and/or there are	

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		missing pages for particular documents, the Monitoring Team assumes they do not exist. It is essential that the Facility ensure that all requested records are made available for onsite as well as for offsite review. Because of the missing nursing assessments noted above, only six of the eight nursing assessments were reviewed by using a monitoring tool comparable to the Facility's Annual Nursing Assessment Monitoring Tool: The review found an overall compliance score of 67%. This was a regression from the overall compliance score of 77% found at the last compliance review. In addition to lack of timeliness in completing nursing assessments, the most essential items on the tool that fell below 90% compliance included: o Three of six (50%) nursing assessments showed all diagnostic testing/screening, including dates due for standing labs orders, frequency, abnormal results, dates of diagnostic tests and/or procedures and/or screenings, as well as summary analyses of data, particularly for abnormal results. o Two of six (33%) nursing assessments showed lists of all medications including dates, types, medications/doses/routes, reason responses, and effectiveness. o Four of six (67%) nursing assessments identified all current nursing problems/diagnoses identified for high and/or medium risk ratings and health problems/diagnoses that might not be rated at high or medium risk but require continuous nursing assessments/monitoring/interventions. o Two of six (33%) nursing assessments indicated health care plans were implemented for all current nursing problems/diagnoses identified for high and/or medium risk ratings and health problems/diagnoses that might not be rated at high or medium risk but require continuous nursing assessments/monitoring/interventions. o Zero of six (0%) nursing assessments for overall summaries sufficiently summarized the individual's health status in relation to their identified high and/or medium risks ratings and/or nursing diagnoses/problems as to whether they were improving, maintaining, or regressing, as well as the effectiveness of their health care plans. • The RN Case Managers were not consistently using the revised DADS Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, April 2013, for completing nursing assessments. The Nursing Operations Officer stated that the Streamlined Nursing Assessment Format sent out in October 2013, was put on hold. However, the first record reviewed used the form. Nursing administration should clarify with the State Office Nursing Coordinator which nursing assessment guidelines and forms are to be used and provide training to the RN Case Managers for the appropriate forms to use.	

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		In summary, these findings, after approximately four years of the Settlement Agreement, continued to demonstrate a substantial lack of compliance with this Provision. As was recommended at the last compliance review, it is essential that the Nursing Administration urgently take corrective action to improve the timeliness, content, and quality of nursing assessments. Based on the Monitoring Team's independent review and the Facility's Self-Assessment, this Provision was not found in substantial compliance. 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 full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. <u>Monitoring Team Findings:</u> The Monitoring Team validated the health care plan information presented in the Facility's Self-Assessment through: Review of the information presented in Section M Presentation Book; review of medical records and other documents requested; conducting interviews with the Chief Nurse Executive, Nursing Operations Officer, Unit Nurse Manager, Nurse Educator, and QE Nurse, attendance at ISP and ISPA Meetings. 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. Due to the Facility's request for a reduced review, the feedback on health care plans is limited. <u>Training Activities:</u> • The Nurse Educator provided training on the Acute Care Plan: Process and Implementation throughout October 2013. A total of 34 of 36 (94%) nurses were trained. An Acute Care Plan was to be initiated within 12 hours of acute illness/injury. A RN must initiate an Acute Care Plan in its entirety. Detailed instructions were included in Acute Care Plan: Process and Implementation. <u>The Monitoring Team's Review of Acute Care Plans for Recent Infections:</u> 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. The five recent reported infections were for Individuals #61, #133, #5, #98, and #15. A review of the five Acute Care Plans showed regression in performance from	Noncompliance

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		the last compliance review: • Zero of five (0%) Acute Care Plans contained any baseline data that describe what lead up to the necessity for a care plan. • Zero of five (0%) Acute Care Plans had realistic, measurable, and/or observable outcome goals related to the acute problems. • Zero of five (0%) Acute Care Plans were individualized sufficient to meeting the individuals' health care needs. All were copied stock care plans without adequate individualization. • Zero of five (0%) Acute Care Plans incorporated relevant nursing protocols and/or physician orders that required nursing interventions. • Zero of five (0%) Acute Care Plans were integrated with other relevant disciplines. • Zero of five (0%) Acute Care Plans included the frequency for monitoring. • One of five (20%) Acute Care Plans included instructions for the direct support professionals. The instruction sheets did include the signatures of the Home Managers and direct support professionals. A review of Individuals' #61, #133, #5, #98, and #15 Integrated Progress Notes related to Acute Care Plans for infections found: • Four of five (80%) Integrated Progress Notes contained documentation that the Infection Control Preventionist was notified. • Zero of five (0%) Integrated Progress Notes contained adequate documentation required by the Antibiotic Protocol. If a resolution note was documented, the note simply stated, "Antibiotic therapy was completed." • Zero of five (0%) Integrated Progress Notes were consistently documented in the SOAP format. • Zero of five (0%) Integrated Progress Notes included documentation that Acute Care Plans had been initiated and the direct support professionals trained. The failure to develop, implement, and follow Acute Care Plans and related nursing protocols sufficiently to meet individuals' health care needs places all of the individuals at risk for harm. Even though it was reported that 94% of the nursing staff were recently trained in Acute Care Plan Processes and Implementation, it is essential that Nursing Administration reinforce the training, as well as training on the Nursing Protocol Cards, and increase monitoring of acute illnesses and injuries to improve the quality of nursing care provided. <u>The Monitoring Team's Review of Nursing Discharge Summaries and accompanying Discharge Packets:</u> According to the Facility's Self-Assessment, Nursing Discharge Summaries forms were used. The Facility's Self-Assessment reported five of six Nursing Discharge Summaries	

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		were done making it 83% compliance. This was not consistent with the Monitoring Teams' review/findings of the individuals' Nursing Discharge Summaries and accompanying Discharge Packages reported below. The Monitoring Team reviewed three Nursing Discharge Summaries and accompanying Discharge Packets for Individuals #62, #47, and #75 who were recently discharged into community living. Findings included: • Zero of three (0%) Nursing Discharge Summaries were used. Two of three (66%) were completed on Comprehensive Nursing Assessment Forms, which were completed within 45 days of community placement. • Zero of three (0%) Comprehensive Nursing Assessment or other nursing data contained in the Discharge Packets sufficiently included individuals' assessments, clinical services needs, and health status in relation to each significant identified health clinical indicator, such that the receiving agency could understand their present health status in order to respond to their health care needs. • Zero of three (0%) Comprehensive Nursing Assessments or other nursing data contained in the Discharge Packets sufficiently contained documentation regarding review/training provided to the group home nurses on individuals' preferences. • Zero of three (0%) Comprehensive Nursing Assessments or other nursing data contained in the Discharge Packets sufficiently contained documentation regarding review/training provided to the group home nurses on individuals' Special Instructions as stated in the Nursing Discharge Summary Form. Review of Community Living Discharge Plans (CLDPs), Post Move Monitoring Checklists, and other transition documentation found that, for three of three individuals (100%), documentation was provided of training on "medical needs, medications, side effects" but the assessments did not clarify what specific issues regarding the individual needed training, what specifically was to be covered in the training, and what competencies should be checked; the CLDPs and post move monitoring documents also did not identify clearly what was trained. This comment relates also to the next four bullets. • Zero of three (0%) Comprehensive Nursing Assessment or other nursing data contained in the Discharge Packets sufficiently contained documentation regarding review/training provided to the group home nurses on individuals' medications. • Zero of three (0%) Comprehensive Nursing Assessment or other nursing data contained in the Discharge Packets sufficiently contained documentation regarding review/training provided to the group home nurses on individuals' Immunization Records • Zero of three (0%) Comprehensive Nursing Assessment or other nursing data contained in the Discharge Packets sufficiently contained documentation regarding review/training provided to the group home nurses on individuals' MOSES/DISCUS,	

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		as applicable. • Zero of three (0%) Comprehensive Nursing Assessment or other nursing data contained in the Discharge Packets sufficiently contained documentation regarding review/training provided to the group home nurses on individuals' IRRF. • Zero of three (0%) Comprehensive Nursing Assessment or other nursing data contained in the Discharge Packets sufficiently contained documentation regarding review/training provided to the group home nurses on individuals' IHCP and/or other related health care plans, as needed. The RN Case Manager should use the required Nursing Discharge Summary Form for Community Living Discharge Planning. Nursing administration should consult with the State Office Nursing Coordinator to clarify the requirements for completing the Nursing Discharge Summaries. Based on the Monitoring Team's independent review and the Facility's Self-Assessment, this Provision was not found in substantial compliance. Refer to Provision M.5 for the report on the IRRFs and IHCPs progress.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. The Monitoring Team validated the Nursing Education information presented in the Facility's Self-Assessment through: Review of the Nursing Education information presented in the Section M Presentation Book; conducting interviews with the Chief Nurse Executive, Nursing Operations Officer, Nurse Educator, Unit Nurse Manager, and QE Nurse, and training documents. Relevant Self-Assessment 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. Due to the Facility's request for a reduced review the feedback on Nursing Education Program is limited. <u>Monitoring Team Findings</u> <u>New Policies, Procedures, Processes and Protocols:</u> • RGSC SOP NR200-34, Nursing Services Infection Control Objectives, May 2013 • RGSC SOP NR200-33, Infection Control Admission Policy, May 2013	

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		• RGSC SOP NR200-79, Infection Control Admission Policy, May 2013 • RGSC SOP ICF-IID 0-16, Premedication for Medical and Dental Procedures, October 2013 • RGSC SOP ICF-IID-Anticoagulation Therapy Protocols, (approved July 2013) • RGSC SOP ICF-IID 400-16, Oral Suction Toothbrushing (approved August 2013) • RGSC SOP ICF-IID 400-18, Hospice Services (approved October 2013) • RGSC SOP NR 200-52, Deep Venous Thrombosis Assessment of Risk and Treatment (approved August 2013) • RGSC PNMP Nurse Post Hospitalization Assessment/Evaluation Form (approved May 2013) These policies, procedures, and protocols were listed in the document request, but copies were not made available for review. <u>Nursing Education and Training Activities:</u> It was positive to find since the last compliance review that the recently hired Nurse Educator had begun making progress in revamping and reorganizing the Nursing Education Program. The annual refresher and New Nurse Orientation training was competency-based using the Nurse Educator Handbook approved by the state office. The Nurse Educator was in the process of refining and maintaining a centralized, comprehensive, and up to date Nursing Education Training Database. The database included the title of the trainings, the names of each nurse trained, and identified whether they were facility or agency nurses. The database was beginning to include the overall percentage of the nurses completing the required training with the expected date for completion. The education information reviewed included: • According the Facility's Self-Assessment results, since the last compliance review, there were Competency Training and Development (CTD) scores of 99% and 100% achieved in August 2013 and September 2013 respectively for the required Facility training. However, there was no supporting documentation supplied that identified what trainings were scored. There were no random reviews of records completed to ensure Nursing Protocol Card documentation compliance. • The 2013-2014 At a Glance ICF-IID Nurse Refresher Training Schedule was provided for review. It identified future training topics scheduled by month and week for August 2013 through July 2014. The formalized schedule was an improvement from previous reviews. • Topical outlines listed in the refresher training schedule, as well as an outline of the Nursing Orientation Books for training on policies and nursing competencies was provided for review. The review found that all required training for nurses was included in the outlines. • Copies of the 2013-2014 Nurse Education and Training Databases for May 2013 through October 2013 and May 2013 through November 2013 were provided for	

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		review. This information was given in a raw data format without summarization or analysis. The May 2013 through October 2013 database included the names of nurses trained, title of all training provided, the date training occurred for each nurse, and the expected date for completion. The May 2013 through November 2013 database included the same information, with the exception of limited titles of training provided. Neither of the databases included an overall calculation of percentage for the nurses trained on all of the titles listed. Therefore, it was not possible to determine the percentage for the overall training status for all required trainings. In order for the Nurse Educator to accurately track the overall status of training, the Monitoring Team suggests that a system be developed and implemented to summarize the overall percentage of nurses trained and update the status of training periodically, preferably monthly. This would assist the Nurse Educator and the Nursing Department in readily keeping abreast of the overall status of training. The Monitoring Team was not provided Nursing Protocol Tool Audit data, although the RGSC Quality Assurance Plan for nursing indicated monthly audits were to be conducted on tools selected for audits, which included the Aspiration Protocol Audit Tool and Constipation Protocol Audit Tool. The Monitoring Team independently used the set of Protocol Cards to monitor for compliance in records reviewed and reported those findings in other relevant Provisions of the report. It was found in reviewing the above records for compliance with the Protocol cards, when indicated, they were not consistently followed. In an effort to move forward with substantial compliance with this Provision it is essential that the Nursing Department ensure that relevant Protocol Cards are consistently followed through to resolution and documented in the Integrated Progress Notes and/or in other relevant documents. The Facility's Self-rating stated this provision is not in substantial compliance and the Monitoring Team concurs. In order to achieve substantial compliance with this provision the Nursing Department must demonstrate that all nursing staff receive training in the required policies, procedures, processes, and protocols; and that they are consistently followed through to resolution to sufficiently to meet individuals health care needs. The positive practices identified in the report should be maintained and improvements made in other areas of practice in order to achieve substantial compliance. Based on the Monitoring Team's independent review and the Facility's Self-Assessment, this Provision was not found in substantial compliance.	
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	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. The Monitoring Team validated the Risk Management information presented in the	Noncompliance

#	Provision	Assessment of Status	Compliance
	assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	Facility's Self-Assessment through: Review of the Risk Management information presented in Section M Presentation Book; review of active records and documents requested; conducting interviews with Chief Nurse Executive, Nursing Operations Officer, Unit Nurse Manager, Nurse Educator, and QE Nurse, and attendance at ISP and ISPA meetings. 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 and the Monitoring Team concurs with their findings. Due to the Facility's request for a reduced review, the feedback on risk management is limited. <u>Monitoring Team's Review of Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) Processes:</u> From the Monitoring Team's review of the records, the IRRF and IHCP processes were continuing to evolve, but were not yet fully implemented, and interdisciplinary teams were not yet proficient in assessing risk ratings and developing integrated health care plans for identified risk ratings. All Health Maintenance Plans had been discontinued. The Monitoring Team reviewed two records from each of the four RN Case Managers selected by the Facility. The most recent Comprehensive Annual/Quarterly Nursing Assessments, Integrated Risk Rating Forms IRRFs and IHCPs were reviewed for Individuals #36, #4, #126, #145, #48, #65, #150 and #139: Since the most recent nursing assessments for Individual #150 was missing and every other page was missing from Individual #139's most recent nursing assessment, those records were not included in the overall review because it was not possible to determine the current health status of these individuals in relation to their high/medium risk ratings and health care services and supports provided. Other documents requested for the comprehensive record review to validate the HICPs were implemented and carried out were not provided for review. When records requested are not provided for review and/or there are missing pages for particular documents, the Monitoring Team assumes they do not exist. It is essential that the Facility ensure that all requested records are made available for onsite as well as for offsite review. <u>Monitoring Team's Review of IRRFs and IHCPs for Individuals #36, #4, #126, #145, #48, #65:</u> • Four of five (80%) IRRFs identified significant changes in some of the risk ratings. • Six of six (100%) IRRFs had interdisciplinary assessments completed. • Five of six (83%) IRRFs' assessments provided clinical data that helped to develop plans to address risk.	

#	Provision	Assessment of Status	Compliance
		• Four of six (67%) IHCPs indicated they were approved and implemented by the IDTs within 14 days. • Two of six (33%) IHCPs were clinically sufficient to meeting the needs for all identified risk ratings. Medium risk ratings did not consistently have plans. • Three of three (50%) IHCPs included preventative interventions to minimize all identified risk ratings. • Two of six (33%) IHCPs were sufficiently integrated among all relevant disciplines. • One of six (17%) IHCPS contained functional and measurable objectives to measure the efficacy of all plans. • Two of six (33%) IHCPs identified clinical indicators for all risk ratings to be monitored and the frequency for monitoring. • Five of six (83%) IRRFs and IHCPS were attached to the ISPs. • Zero of six (0%) had Integrated Direct Care Professional Instructions Sheets attached to the IHCPs. While touring La Paloma with the Nursing Operations Officer and QE Nurse, the Monitoring Team attempted to locate the Direct Care Professional Instruction Sheets in the "Me Books" for Individuals #36, #150, #126, and #4. None of the Direct Care Professional Instruction Sheets were found in the "Me Books" as required. The Nursing Operations Officer was asked to check on all eight individuals selected for review to determine whether Direct Care Professional Instruction Sheets were developed and implemented and/or just not in the "Me Books". After some investigation by the Nursing Operations Officer, he reported that the Direct Care Professional Instruction Sheets had not been developed and implemented for any of the eight individuals. Upon this discovery, the Nursing Operations Officer promptly conducted a meeting with all four RN Case Managers and instructed them to correct the problem immediately. <u>Monitoring Team's Review of Bowel Monitoring Tracking Data and Observations:</u> It was positive to find that the Bowel Monitoring Tracking Data was being reviewed daily by the floor nursing staff. This had been identified as deficiency in the previous review. This was validated through an informal observation made where a floor nurse was in the process of reviewing the Bowel Monitoring Tracking Database online and making note of individuals who were documented as not having bowel eliminations reported for three days. The floor nurse stated the nurse followed-up with the individuals and direct care professionals to assess elimination status and if found individuals had not had bowel eliminations as documented, the nurse intervened according to individuals' physician order's and/or plans of care. Further validation that bowel monitoring was being done was through review of the Bowel Monitoring Data found in the active records for Individuals #36, #4, #126, #145, #48, #65, #150, and #136; for date range 8/1/13 through 11/20/13.	

#	Provision	Assessment of Status	Compliance
		In summary, as was found in past reviews, the IRRF and IHCP processes were evolving. As more training is provided and experience is gained by the IDTs and the respective disciplines in developing and implementing these processes, continued improvements should be made in the content of the clinical data and quality of these processes. There continued to be variation in the content and quality of IRRFs and IHCPs completed by different IDTs. It is essential that the IDTs and respective disciplines consider the interrelationship of risk factors within a category and between categories 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. Based on the Monitoring Team's independent review and the Facility's Self-Assessment, this Provision was not found in substantial compliance.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. <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 Section M Presentation Book and document requests; conducting interviews with the Chief Executive Nurse, Nursing Operations Officer, Unit Nurse Manager, Nurse Educator, and QE Nurse; inspections/observations of units' Medication Rooms; review of Units' Medication Administration Record Notebooks, and conducting Medication Administration 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.6 and the Monitoring team concurs. Due to the Facility's request for a reduced review, the feedback on the medication management processes is limited <u>Medication Administration Training:</u> According to the Facility's Self-Assessment results, Medication Administration for Individuals with Dysphagia and/or Swallowing Difficulties classes were periodically taught over the months of April 2013 and September 2013. During this time period 17 of 17 (100%) full time nurses were reported to have completed the training and 17 of 21 (81%) of the agency nurses were reported to have completed the training.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Medication Variance Data and Medication Management Workgroup and Pharmacy and Therapeutics Committees Meetings: The Facility continued to maintain a monthly, quarterly, and longitudinal system for reporting and analyzing medication variances. The medication variance system represented the data in tabular charts, bar graphs, linear graphs, and pie charts. Data were reported for severity index categories, whether the errors reached the individuals, day of week the medication errors occurred, medication process, by type, cause, location and total medication errors/variances by location. The chart below shows the overall number of medication variances reported from March 2013 through September 2013, by number of total medication variances reported for La Paloma and El Paisano. In addition, the chart shows the number of medication variances by responsible disciplines:	

Medication Variances

Month and Year	La Paloma	El Paisano	Nursing	Pharmacy	Total
March 2013	8	8	15	1	16
April 2013	4	2	5	1	6
May 2013	8	1	9	0	9
June 2013	0	1	0	1	1
July 2013	0	0	2	0	2
August 2013	4	1	5	0	5
September 2013	9	4	5	8	13
Total	25	17	41	11	52

Attached to the above data was the FY2013 Facility Wide (Mental Health and ICF-IDD) Medication Variances by Month for Inpatient Services data, prepared 10/17/13 for presentation to the Pharmacy and Therapeutic Committee. The data in the charts were represented in tabular charts, linear graphs, bar graphs, and pie charts with accompanying text boxes and/or narrative explanations describing the data both in general terms, as well specific to either Mental Health or IFC-IID and some proposed measures to implement to reduce and/or prevent the incidences of medication variances. A narrative explanation stated there were no medication variances committed by the medical discipline. This statement was questionable because the medical discipline is just as likely to commit medication variances as the nursing and pharmacy disciplines. More attention should be paid to analyzing medication variances for the medical discipline to ensure they are reporting their medication variances and are taking appropriate corrective actions.

The only monthly Medication Management Workgroup Notes provided since the last compliance review was for 7/23/13. The cover sheet responding to the request for the

#	Provision	Assessment of Status	Compliance
		last six months of the Medication Error/Variance Committee minutes stated, "Not applicable, refer to P & T Committee." However, the only Pharmacy and Therapeutics Sub-Committee Meeting Minutes provided since the last compliance review was for 6/26/13. Only the agenda for the 10/17/13 Pharmacy and Therapeutics Sub-Committee Meeting was provided for review. The Medication Management Workgroup Meeting scheduled for 11/21/13, during the compliance visit was canceled. Therefore, the status of issues reviewed, discussed, and decisions made regarding current medication management practices, including corrective actions and their effectiveness in reducing and/or preventing medication variances, could not be determined. A review of the data presented to SA-PIC at the 11/21/13 meeting did not include reports on medication variances. <u>Other Medication Error/Variance data provided for review included:</u> • The Facility provided for review Medication Error Investigation Reports for Mental Health and ICF-IID for each medication error investigated for a total of 153 pages of documents, with a date range from March 2013 through November 2013, as well as the accompanying DSHS-RGSC Medication Investigation Summary Report for Mental Health and ICF-IDD, date range from 4/11/13 through 9/30/13. The data described in the report was for each individual medication error/variance and included the discipline responsible for committing the variance and the corrective action. The raw data of numbers represented, in tabular charts, severity index categories, whether the errors reached the individuals, day of week the medication errors occurred, medication process, by type, cause, location and total medication errors/variances by location; there was no further analysis and trending of the data to identify local and/or systemic trends that would assist the Facility in decision making to reduce and/or prevent the incidences of medication variances. • DSHS-RGSC Reports of Medication Errors Filed in the Crystal Reports by individuals for which the medication errors/variances were committed. There was no accompanying analysis and trending of data to identify local and/or systemic trends that would assist the Facility in decision making to reduce and/or prevent the incidences of medication variances. In summary, none of the voluminous amount of medication variance reports of data above analyzed and trended the medication variance data sufficiently to identify systemic trends in order for the Facility to take meaningful and sustaining corrective actions. For future compliance reviews, the Facility should only report medication variance data specifically for ICF-IID. Providing the Monitoring Team with volumes of medication variance data comingled with Mental Health data made the accuracy of determining the status of ICF-IID compliance with the medication variance policy impossible.	

#	Provision	Assessment of Status	Compliance
		Monitoring Team's Review of 10 Most Recently Completed Medication Variances: The Facility did not provide hard copies of the 10 most recent Medication Variance Reports documented on the standardized reporting form for review, as was provided at the last compliance review. Improvements Made in Medication Management Processes: Although the above medication variance reports of data were not sufficiently analyzed specifically for local and systemic trends, and lacked Medication Management Workgroup Notes and recent Pharmacy and Therapeutic Sub-Committee Meeting minutes, it was positive to find through the Monitoring Team's interview with Nursing Administrative staff, observations, and review of documents that improvements were made very recently in medication management processes that should lead to a reduction in the incidences of medication variances and assist the Facility move forward toward compliance with the Provision. The improvements included: • Medication Administration for Individuals with Dysphagia and/or Swallowing Difficulties classes were periodically taught over the months of April 2013 and September 2013. During this time period 17 of 17 (100%) full time nurses were reported to have completed the training and 17 of 21 (81%) of the agency nurses were reported to have completed the training. • There had been development and implementation of formalized Medication Error Processes: o Discovery Process: Several processes were put in place to ensure timely identification of medication errors. The Medication Administration Record (MAR) was checked daily for any omissions. A full medication cart count using the MARs as a cross-check was conducted twice daily at 2:00 p.m. and 10:00 p.m. The count was completed in unison by the outgoing and incoming nurses to provide for accuracy. The full medication cart counts allowed for rapid identification of medication overages and/or shortages. Upon the identification of any discrepancies, the discovering medication nurse completed a Medication Error Report and notified the Unit Nurse Manager. This triggered an investigation. o Medication Error Investigation: During the medication error investigation, the discovering medication nurse was interviewed to gather any known information. A full medication cart count was then conducted by the investigator to verify discrepancies. The MAR was also examined for any notable errors in documentation. The nurse suspected of committing the medication error was also interviewed for additional information. The information gathered was then used to determine the cause/contributing factors and what can be done to prevent reoccurrence.	

#	Provision	Assessment of Status	Compliance
		○ Corrective Action: Non-punitive correction was emphasized for unintentional medication errors. When medication errors were discovered, the responsible nurse received retraining on identified issues. Routine Medication Administration Observations were also performed, with on the spot training provided as needed. If any system failure was identified, appropriate adjustments were made to the medication administration process and all nurses were retrained. There was a non-punitive focus for a positive environment that diminishes fear and promotes medication error reporting. According to Nursing Administration this was evidenced by a significant increase in rates of medication error reports submitted within the last six months. • A Medication Cart Exchange Process had been implemented. ○ As of 10/22/13, the La Paloma medication cart was split into two carts according to census, allowing a ratio of one nurse to 16 individuals. Medications in the carts were separated into morning and evening medications. Medication cart exchanges take place in the pharmacy, as opposed to the units. This made the reconciliation of medication a smooth process, free from distractions as was the case when the exchange occurred on the units. The two nurses brought the MARs along with the medication carts to the pharmacy. The two medication nurses count and reconcile both carts simultaneously with the two pharmacy technicians. Any discrepancies identified are resolved on the spot during interaction as there was immediate access to the medications. ○ The MARs for both medication carts were divided into two separate notebooks and arranged in alphabetical order. Each tab included the individuals' pictures and face sheet as identifiers, PNMP, Self-Administration of Medication Records, as applicable, MARs, Blood Sugar Monitoring Records and Glucose True Test Records, as applicable, and Universal Signature Sheets. The MAR Notebooks were more organized to allow nurses to efficiently locate individuals' data. ○ La Paloma's first medication cart and MAR Notebook was located in the medication room. The second medication administration area was located in the recently created space in the backroom of the nurse's station where there was a door opening into an alcove where the medication cart was placed in front of the door to pass medication. This area does not have heavy activity, which provides privacy. The direct care professionals (DCPs) bring one individual at a time to the cart to receive their medications. The treatment room was located in the center part of the nurse's station where a curtain with Velcro was installed for privacy to use when individuals receive treatments. The same arrangement will be used in El Paisano once they	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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have all of the necessary equipment to launch the physical change. The second medication cart ordered was projected to arrive 12/2/13. The tentative date for completion of the physical renovation in El Paisano's second medication station was for 12/15/13. The same processes used in La Paloma will be used for El Paisano.
• In October 2013, Unit Nurse Manager had done an excellent job by combining numerous medication management and other nursing management checklists into three checklists for more efficiency and accuracy, as listed: A Nursing Floor Checklist to be performed by assigned floor nurses on each shift, a Drug Storage/Sanitation (Internal and External Separation of Medications), Drug Expiration Dates, Expired Medications, Removal of Worn out Illegible Labels, and Adaptive Devises (Eye Glasses) Checklist to be performed by the assigned nurses on the 6-2 shifts and 2-10 shifts, and a Nursing Supplies and Sanitation Audit Checklist. These checklists will be completed by both La Paloma and El Paisano.

The SA-PIC Audits 2013 Report was provided for review for the above checklists. The results of the audits for May 2013 through October 2013 are shown in the chart below:
<table>
<tr><th>SA-PIC Audit</th><th>May</th><th>June</th><th>July</th><th>August</th><th>September</th><th>October</th></tr>
<tr><td>Storage/Sanitation Internal and External Separation</td><td>100%</td><td>100%</td><td>99%</td><td>100%</td><td>90%</td><td>100%</td></tr>
<tr><td>Drug Expiration Dates</td><td>100%</td><td>100%</td><td>99%</td><td>100%</td><td>90%</td><td>100%</td></tr>
<tr><td>Expired Medications</td><td>100%</td><td>100%</td><td>99%</td><td>100%</td><td>90%</td><td>100%</td></tr>
<tr><td>Removal of Worn out Illegible labels</td><td>100%</td><td>100%</td><td>99%</td><td>100%</td><td>90%</td><td>100%</td></tr>
<tr><td>Insulin Administration</td><td>94%</td><td>96%</td><td>99%</td><td>100%</td><td>89%</td><td>94%</td></tr>
<tr><td>Nursing Supplies and Sanitation Audit</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>80%</td></tr>
</table>
This information was presented at SA-PIC Meeting on 11/21/13. There was no narrative accompanying the data.
• The Unit Nurse Manager sent out a memo regarding Pharmacy Over/Shortage Forms. Effective 9/4/13, they were not to be faxed to the pharmacy. Directions were provided for completing the forms.
• The Refrigerator/Freezer Cleaning Log was revised to ensure this function was performed weekly. Supporting documentation La Paloma and El Paisano was provided that validated that this function was performed as required.

<u>Monitoring Team's Observation of Improvements Made to Medication Management Processes:</u>
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		• The medication cart exchange was observed in the pharmacy for La Paloma. It appeared to go smoothly and efficiently with two nurses and two pharmacy technicians working together to fill the carts. The medications were cross-checked against individuals' MARs. The pharmacist said it should take about an hour and a half if there were no interruptions. The medication cart exchange was also observed for El Paisano. This cart was for approximately 32 individuals. The nurses stated it could not be filled in an hour and a half because there were twice as many medications to check and fill. This exchange did not appear to go as smoothly as the other cart exchange observed. The pharmacist should ensure that adequate time is allotted for the cart exchange to ensure accuracy. When El Paisano splits the carts the process should go smoother and take less time. • The two MAR Notebooks in La Paloma were reviewed alongside of the Nursing Operations Officer and QE Nurse. The information was placed in new notebooks, organized with tabs, and contained all of the required information for each individual. In MAR Notebook number one, one PNMP had not been updated and five individuals MARs did not contain individuals' current medical diagnoses. The Nursing Operations Officer said he would check to see if the out of date PNMP was updated, if so, he would replace it. He will also make sure that the current medical diagnoses were added to individuals' MARs that were missing. Nothing was missing in MAR Notebook number two. The MAR Notebook in El Paisano was also reviewed and was found as complete and well organized as La Paloma's. There were no outdated PNMPs or missing medical diagnoses on individuals' MARs. The MAR Notebooks showed significant improvement from previous compliance review. However, some of the individuals' MARs had other documents located between the MARs and the PNMPs. It was suggested that these documents be moved either in front or behind the PNMPs or MARs and that the PNMP sheets containing instructions for medication administration be turned facing the MARs for ease of visibility when looking at both of these documents. • The Monitoring Team accompanied by the Nursing Operations Officer and QE Nurse checked La Paloma's black tackle box that stored medication for return to the pharmacy. At the last compliance review, medications were placed in the box without individual identification or a completed Pharmacy Excess/Shortage Form. This time each individuals' return medications had identifying labels with a brief reason for the return, i.e., out on pass. However, only approximately half of the return medication packages contained the Pharmacy Excess/Shortage Forms required to provide information explaining the reason for the returns. The Nursing Operations Officer stated he would follow-up with the nursing staff to ensure they completed the forms and placed them in the individuals' packages for return to the pharmacy. The reconciliation process should be followed. Any medications that	

#	Provision	Assessment of Status	Compliance
		were not reconciled should have Medication Variance Reports completed and investigated according to the Medication Error Process as described above. • The refrigerators in the medication rooms were inspected and were found to be clean and free from undue clutter; there were no personal food items in the refrigerators, or open food containers without a date. This was an improvement from previous reviews. • Internal and external medications were separated in both La Paloma and El Paisano medication rooms. The morning and evening medications were separated in the medication carts. All opened medications inspected were labeled and dated. • The biohazard waste containers were not overly full. • The pill crushers were clean. • The refrigerator temperatures for November 2013 were checked and recorded daily. • 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 boards in the medication rooms. • The Nursing Drug Books were present in the nurse's station. • There was continued use of locked storage containers mounted on the walls in the medication rooms to dispose of all expired medications, for which only the Pharmacy had a key for security purpose. <u>Facility's Medication Administration Observation Data:</u> Since the last compliance review, the Nurse Educator was responsible for conducting Medication Administration Audits. The Monitoring Team was provided a Medication Administration Observation Summary for March 2013 through August 2013. The Facility used the state office's standardized Medication Administration Observation Form, dated 10/31/13. Rather than observing all nursing staff, the Facility followed the state's Medication Observation Guidelines, which stated observations must only be done for those nurses who routinely administer medications. A list of all nurses, full time and agency, who routinely administer medications was maintained. These nurses were scheduled on a quarterly basis, to ensure all were observed at least once per quarter. Reducing the list to only those nurses that routinely administer medication should facilitate maintaining 100% completion of the quarterly Medication Administration Observation audits. The spreadsheet showed a total sample size of 22 nurses. The Medication Administration Observation audit data for the last six months demonstrated compliance with the expected standards and procedures during medication administration passes. Twenty one of 22 nurses maintained an average score above 90% for the past six months. In August 2013, one nurse fell below 90% compliance with an observation score of 89%. This nurse received on the spot training with follow-up observations conducted	

#	Provision	Assessment of Status	Compliance
		the next day. The nurse showed marked improvement with a score of 100%. It was positive to find since the last compliance review, that the PNMP staff conducted medication administration observations on both full time and agency nurses to ensure that individuals' PNMPs were followed for safe medication administration. The Monitoring Team was provided with PNMP monitoring data for 8/5/13 through 11/6/13. Twenty three observations were conducted that showed 21 of 23 observations achieved a compliance score of 90% or greater. <u>Monitoring Team's Medication Administration Observations:</u> Medication Administration Observations were conducted at the 4:00 p.m. med passes on 11/18/13 and 11/20/13, accompanied by the QE Nurse and/or Nursing Operations Officer. Three different nurses were observed passing medications. Since the last compliance review, significant improvement was found in the nurses' abilities to follow current and generally accepted standards of safe medication administration practices Findings included: • Before preparing medications for administration, the nurses consistently reviewed the PNMPs' medication administration instructions and were able to explain the rationale for the instructions. The medication administration strategies were consistently followed. When an individual failed to follow the strategies, the nurses redirected them according to their PNMP instructions. One individual was observed attempting to hyperextend the head and neck while drinking liquids after receiving medication. The Nursing Operations Officer stated he would make a referral to the PNMT for a medication observation to evaluate for the need for a nosey cup. It was apparent throughout the medication observations that the Medication Administration Class for Individuals with Dysphagia and/or Swallowing Difficulties had improved their safe medication administration practices. • Before administering medications, the nurses checked the medications prepared against the MARs, followed the five rights, and completed the required three checks. This was an improvement from the previous compliance reviews. • All medications were administered at eye level and in the position stated in the PNMP. This was an improvement from the previous compliance reviews. • The nurses followed proper handwashing techniques throughout the medication observation passes. This was an improvement from previous compliance reviews. • The nurses did not document the medications given until after they were administered. This was an improvement from the previous compliance reviews. • The nurses consistently told the individuals what medications they were receiving and their purpose with one exception. One nurse at the beginning of the medication pass did not tell an individual what medications he was receiving and their purposes. The nurse was immediately prompted by the Nursing Operation Office to do so.	

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		Thereafter, the nurse consistently complied. • During the med pass the nurses informally implemented Self-Administration of Medication programming for individuals' who had a program. The formal Self-Administration of Medication programming for individuals was scheduled on Mondays. Otherwise, informal programming was to take place at each med pass. • It was positive to find that all of the nurses observed were bilingual and were able to converse fluently with individuals whose first language was Spanish. • The direct care professionals assisted the nurse during the med pass by bringing one individual at a time to receive medications. • Individuals were afforded as much privacy as was possible considering medications were passed through designated alcoves created at the doors from which medications were passed. • The MARs and medication carts were split in half in La Paloma where the each nurse administering medications had approximately 1 to 16 ratio of individuals to give medications. This allowed for reduced time and efficiency in administering medications, as well as creating a climate free from distractions. These improvements should assist with reducing and/or preventing the potential for medication variances. The Facility projected that El Paisano's MAR and medication cart would be split like La Paloma 12/15/13 when the physical plant renovations were completed and the new medication cart ordered was available. El Paisano will follow the same processes as for La Paloma. The Monitoring Team's independent review found numerous new medication management processes were recently implemented that should facilitate moving forward toward substantial compliance with this Provision; however, they had not been in place long enough to determine their effectiveness. The Facility should consider conducting more in-depth analyses of medication variance data to identify local and systemic trends, specifically related to ICF-IID, to ensure effective corrective actions are implement for each responsible discipline to reduce/ and or prevent the occurrence of medication variances. In order for substantial compliance to be achieved all requirements of the Medication Variance Policy must be followed The positive practices identified in the report should be maintained and improvements made in other areas of practice in order to achieve substantial compliance. Based on the Monitoring Team's independent review and the Facility's Self-Assessment, this Provision was not found in substantial compliance.	

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 Section Self-Assessment, Updated: 11/6/13 2. RGSC Section Action Plans, Updated: 11/5/13 3. RGSC Section Presentation Book 4. RGSC Standard Operating Procedure NR100-66, dated December 2007 5. Pharmacy and Therapeutic Committee (P&TC) meeting minutes 10/27/2013 6. Medication Management Subcommittee meeting minutes 7/23/2013 7. For Individuals #133, #84, #145, #5, #65, #61, #97, #119, #101, #150, #24, and #131: a. Pharmacy documentation of a review for allergies, interactions, required diagnostics, appropriate indication, and dose b. Past six months laboratory data c. Current medication list d. EKG for past three years e. Most recent ophthalmology report f. Completed SPDI (single patient drug intervention reports) associated with the new medication order 8. For Individuals #108, #81, #46, #51, #2, and #127: a. Most recent two Quarterly Drug Regimen Reviews (QDRRs) b. Past six months MOSES and DISCUS assessments c. Most recent 12 months of lab results d. Most recent two EKG reports e. Most recent annual physician summary f. Most recent psychiatric assessment g. Most recent IRRF 9. For Individuals #59, #2, #15, #67, #97, #77, #79, #11, #55, #19, #127, #145, #108, #81, #46, and #51: a. Most recent two QDRRs b. Current medical list c. Most recent medical, and psychiatric annual reviews d. Most recent MOSES and DISCUS assessments e. Most recent Integrated Risk Review Form (IRRF) f. Psychiatric assessment 10. Anticholinergics report, undated 11. POMC meeting minutes for 10/17/2013 12. List of all individuals on polypharmacy 13. Adverse Drug Reaction Report (ADR), undated 14. Completed Drug Utilization Evaluations (DUEs) for Coumadin, ziprasidone, fluoxetine **People Interviewed:** 1. Anne Ikponmwonba, RPh (director of pharmacy)

	2. David Moron, MD (Clinical Director) 3. Gary Sauceta (Information Technologist) **Meeting Attended/Observations:** 1. None
	Facility Self-Assessment: The Facility assessed that it was in substantial compliance with all eight subsections. The Monitoring Team concurs with the self-assessment of substantial compliance for Section N.1 and has maintained the finding of substantial compliance for Section N.4, but disagrees with the self-assessment of substantial compliance with Sections N.2, N.3, and N.5 through N.8. The following are some comments, and concerns noted with the Facility's self-assessment process: • The self-assessment for Section N.2 determined that 100% of the QDRRs completed were on time; however, the Monitoring Team was not provided a schedule that clearly delineated due dates and previous dates that QDRRs were completed, and also noted that on numerous QDRRs, the date of completion was well outside the time frame from the previous QDRR, hence, QDRRs were not completed within a quarterly time frame. • For Section N.3, the Facility reported, "when an emergency chemical restraint for behaviors was needed, reviews for the events were conducted to ensure clinical appropriateness". In this case, the Monitoring Team was informed that there were no chemical restraints administered during the time frame that was assessed. The self assessment for Section N.3 also indicated that "the pharmacist appropriately addressed 7 chemical restraints, 7 anticholinergic stat uses, 34 polypharmacy instances, and 2 metabolic risks in 100% of the time." The Monitoring Team was unable to determine what exactly the self-assessment was actually assessing. • For Section N.4, the self-assessment indicated that the prescribers "appropriately reviewed Quarterly Drug Regimen Reviews"; however, the Monitoring Team noted in numerous occasions that the psychiatrist did not address the recommendations made on the QDRRs. • For Section N.5, the self-assessment stated "100% compliance; individuals receiving psychotropic medication are appropriately monitored for side effects and the clinical pharmacist is appropriately noting the results of these evaluation on the QDRRs". The Monitoring Team noted numerous examples of MOSES and DISCUS assessments not being completed as clinically necessary. For example, when a neuroleptic medication is added or dose changed, there should be additional monitoring on several occasions after the medication change. This was not noted by the documents provided for review. • For Section N.6, the self-assessment indicated that in "100% of all ADRs reported were investigated by the pharmacist"; "100% of ADRs reported were presented to the P&T Committee"; and "100% of recommendations/clinical plans made at the initial P&T Committee meeting were followed up at the subsequent P&T Committee meeting". The Monitoring Team could not concur with these findings through its review of the documents provided for this Section. The Facility should re-evaluate its self-assessment process to ensure that the self-assessment takes into consideration not only if an action item was completed, but also if the action item is effective and enhances clinical activities at the Facility. There were many examples noted in the self-assessment where

	effectiveness of an action item was not assessed, and where action items were not completely assessed--for example, indicating that the QDRRs were completed timely, but not assessing if the QDRRs clearly delineated all of the relevant clinical issues that are required of a QDRR. In addition, it is essential that the data presented is consistent across sections of the Settlement Agreement requirements and in all documentation. The data on chemical restraints provided in the Section N Self-Assessment is inconsistent with reports provided to the Monitoring Team in other documentation. One way to address this would be to include this information in, or draw it from, the Facility's routine quality assurance data reports.
	Summary of Monitor's Assessment: The Monitoring Team concurred with the Facility's self-assessment of substantial compliance of Section N.1, noting significant improvement with the Facility's assessment of new medications. Sections N.2 through N.8 were determined to be not in compliance. Each noncompliant Section demonstrated significant deficits, in many areas, that prevent substantial compliance. The Following are some comments and concerns specific for each Section: Section N.1: Because all new medication orders reviewed demonstrated that the pharmacists documented review for clinical appropriateness, allergies, interactions, appropriate dose and necessary clinical diagnostics, the Monitoring Team determined that the Facility is in substantial compliance with Provision N.1. Section N.2: The Monitoring Team determined that the Facility was not in compliance with Section N.2, and must continue to enhance its QDRR process by ensuring that QDRRs are completed at least quarterly; document the appropriateness of all medications prescribed; and ensure that the psychiatrist reviews, signs, and acts upon QDRRs that include the use of medications for psychiatric indications. Section N.3: Review of QDRRs indicated significant delay in completing QDRRs within the quarterly time frame. The Facility must immediately address this delay. The Facility must also enhance the QDRR process with regard to its review of polypharmacy, benzodiazepine, and anticholinergic drug usage, and review of metabolic syndrome. The Facility performs excellent systems, and individual, review of polypharmacy, but systems review of metabolic syndrome, and of benzodiazepine and anticholinergic drug usage, must be improved. For example, the pharmacist must ensure that a review of metabolic syndrome is well documented on the QDRR whenever there is a drug prescribed that is known to cause metabolic syndrome. The pharmacist must document agreement or disagreement with the indication, appropriateness, and dosage of benzodiazepine, anticholinergic, and polypharmacy related drugs, and provide specific clinical recommendations to minimize the use of these drugs, when clinically appropriate. The Facility must include in its review of anticholinergics all drugs with anticholinergic properties, not just Cogentin. Because of these findings, the Monitoring Team determined that the Facility in not in compliance with Section N.3. Section N.4: The psychiatrist did not indicate review of the QDRRs, and did not indicate either agreement

	or disagreement with the pharmacist's recommendation, as was done at the last compliance visit. The Monitoring Team is retaining a finding of substantial compliance with Section N.4, but the Facility must ensure that for all QDRRs that include review of a psychotropic medication, or other medications used for a psychiatric indication, the psychiatrist must review and sign the QDRR, and ensure that the pharmacist's recommendations are agreed or disagreed upon, and indicate a clinically relevant action plan when the recommendations are not agreed upon. Section N.5: Although the prescriber signed, dated, and completed the prescriber component of the assessment tools, the Facility did not perform more frequent monitoring for emerging side effects secondary to a dose increase, or addition of a new neuroleptic. For this reason, the Facility is not in compliance with Section N.5. Section N.6: Because the Facility did not have a policy and procedure for its ADR process; did not provide a list of staff that required ADR training; did not have an effective mechanism to track and trend ADRs; and did not provide the requested documentation for the one ADR reported, the Monitoring Team determined that the Facility was not in compliance with Section N.6. Section N.7: The Facility did not provide information on the scheduled DUE for benztropine, and did not use a unified process to evaluate drug usage. For example, the Facility utilized a Drug Audit Checklist for Coumadin and ziprasidone, but not for fluoxetine, and the Facility completed a Medication Summary Report form for fluoxetine and ziprasidone, but not Coumadin. The Facility did not maintain a formal calendar to track all DUEs, which is important because a calendar would enable efficient review of all DUEs provided, pending, and completed, and enable the Facility to periodically reassess DUE-related issues. There was no evidence to indicate that the Facility had a dedicated process to track pharmacist's recommendations for DUEs through completion, and to assess the efficacy of recommendations. There was no indication that medical providers were provided in-service materials related to the completed DUEs, and review of the one set of P&TC minutes provided for review only included a very cursory overview of the findings of the DUE for fluoxetine, with no indication if system improvements were necessary or not. The P&TC minutes also included a statement related to the DUE for Coumadin, stating "the same two patients on Coumadin for the 4th Qtr. Everything is normal. All patients in therapeutic range". The associated DUE for Coumadin, however, indicated that there were three individuals on Coumadin, and were assessed by the DUE. There was no documentation indicating that DUEs were developed for FDA advisories. The Facility must ensure that medical providers, and pharmacists are provided a specific in-service materials for DUEs developed for FDA advisories, or other forms of informational materials for specific classes of drug that are commonly used in general medicine and psychiatry, but not currently utilized at the Facility. The Monitoring Team determined that the Facility is not in compliance with Section N.7, and strongly encourages that the Facility enhance its DUE process. Section N.8: The Facility requested limited review of Section M.6, because of self identified lack of improvement in the area of medication variance. Sections N.8 and M.6 are closely linked, and therefore the Facility's report of lack of improvement for Section M.6 can be extrapolated to Section N.8. For its review of Section N.8, the Monitoring Team noted that the Facility's primary policy for medication variances had not

	been updated since 2007, and this concern was commented on in the last report. The Facility provided a set of committee meeting minutes for the Medication Management Workgroup meeting, dated 7/23/2013, and P&TC sub committee meeting minutes, dated 10/17/2013. The workgroup meeting minutes delineated relevant data; however, there were no examples of the data being analyzed and trended sufficiently to identify systemic trends; this analysis is essential in order for the Facility to take meaningful and sustaining corrective actions. The Facility did not provide copies of completed medication variance reports. The Monitoring Team was also concerned because many of the data fields indicating what discipline caused the variance only included fields for pharmacy and nursing, and no field for medical. The Monitoring Team determined noncompliance for Section N.8, and strongly recommends that the Facility enhance its medication variance process by ensuring that medical providers are closely monitoring for medication variances; that all relevant staff, including pharmacists, nurses, and medical providers are well trained on reporting of medication variances; that the Facility medication variance process is delineated within the context of current policies and procedures; that there is comprehensive and meaningful analysis of medication variance data, that includes a trend analysis; that all relevant staff, including nurses and medical providers follow-up on each reported medication variance, and document their physical assessment of the individual within an integrated progress note (IPN); that action plans are developed, with specific follow-up to completion, and assessment of efficacy of the action plan; and that P&TC members conduct comprehensive review of medication variances.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug	Provision N.1 requires that a pharmacist reviews all new medication orders to ensure that the medication is for a clinically appropriate indication; evaluate all diagnostics necessary for safe administration of the medication; evaluate efficacy of the drug; ensure that the dose is clinically appropriate; and ensure that there were no contraindications, such as allergies, and drug-drug interactions. The pharmacist utilizes the WORx, drug safety computer program, when reviewing all medication orders. The WORx program is an automated process that assesses for possible drug-drug interactions, known allergies, and prompts the pharmacist to review necessary diagnostics. To document the pharmacist's review of new medication orders, the pharmacist completes a checklist, which is stamped on each new medication order. The stamp includes notation for appropriate indication, evaluation of labs, assessment for allergies, and dose. To assess compliance with Provision N.1, the Monitoring Team reviewed copies of the first two medication orders of each month, for June 2013 through November 2013, for a total of ten new medication orders. In addition, the following information was reviewed for each example provided (Individuals #133, #84, #145, #5, #65, #61, #97, #119, #101, #150, #24, and #131) • Pharmacy documentation of a review for allergies, interactions, required	Substantial Compliance

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	literature.	diagnostics, appropriate indication, and dose • Past six months laboratory data • Current medication list • EKG for past three years • Most recent ophthalmology report • Completed SPDI (single patient drug intervention reports) associated with the new medication order The following is a summary of the Monitoring Team's review: • The pharmacist reviewed all new medication orders for potential allergies, interactions, appropriate doses, necessary diagnostics, and indications in ten out of ten examples (100%). • The Monitoring Team reviewed the medication order for potential drug interactions with the medication listed on the current medication list, and in ten out of ten examples (100%), the Monitoring Team identified no evidence of drug-drug interactions. • There were three examples requiring the initiation of a SPDI (Individuals #133, #145, #65) and in three out of the three examples (100%) there was evidence to indicate that the medical provider appropriately addressed the SPDI by the pharmacist. • When clinically indicated, necessary laboratory diagnostics, EKGs, and consultations were obtained in ten out of ten examples (100%). • Documentation of the pharmacist's review of the medication orders was completed on the same day as the order was written by the medical provider in ten out of ten examples (100%). Conclusion Because all new medication orders reviewed demonstrated that the pharmacists documented review for clinical appropriateness, allergies, interactions, appropriate dose and necessary clinical diagnostics, the Monitoring Team determined that the Facility is in substantial compliance with Provision N.1.	
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 Facility conducts quarterly drug regimen reviews (QDRRs), that are consistent with generally acceptable standard of care practice, and that the QDRRs are completed within the Facility's 14 day window for scheduled completion of QDRRs, the Monitoring Team reviewed the following documents: • QDRR schedule for past six months, and pending six months • List of all QDRRs, for the past six months, that were not completed within 14 days of the scheduled completion date • Average daily census	Noncompliance

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		• Alpha list of individuals who were prescribed a neuroleptic and have diabetes • Alpha list of individuals who were prescribed a neuroleptic and have diagnosis of hypertension • Alpha list of individuals who were prescribed a benzodiazepine • Alpha list of all individuals with diagnosis of osteoporosis • Alpha list of all individuals with diagnosis of seizure disorder • The Monitoring Team selected the following examples from the alpha lists (Individuals #108, #81, #46, #51, #2, and #127): o Most recent two QDRRs o Past six months MOSES and DISCUS assessments o Most recent 12 months of lab results o Most recent two EKG reports o Most recent annual physician summary o Most recent psychiatric assessment o Most recent IRRF o Current medication list o Evidence that the medical providers reviewed the pharmacists' recommendations; indication if they agreed or disagreed with the recommendations; and if disagreed, documentation of their clinical rationale The Facility did not provide the requested alpha list of all individuals whose QDRR was not completed within 14 days from the scheduled review date. The Facility provided a list of Individuals, that was not labeled, was not an alpha list, and the Monitoring Team was unable to determine if QDRRs were completed as scheduled. The following is a summary of the Monitoring Team review of the examples provided for Individuals #108, #81, #46, #51, #2, and #127). • Of the 6 examples, there were two instances of polypharmacy, and in zero out of two examples (0%), the pharmacist addressed polypharmacy, and included a specific statement indicating the appropriateness of polypharmacy. • For the two individuals treated with benzodiazepines, zero out of two (0%) examples indicated a specific assessment for the use of benzodiazepine by the pharmacist that included a statement indicating the clinical appropriateness for continued scheduled administration. • The pharmacist assessed Laboratory and other diagnostics, such as EKGs and DEXA scans, in six out of six examples (100%). • Metabolic syndrome was appropriately assessed in three out of the three examples (100%) that required a review for metabolic syndrome. • The Monitoring Team began at this visit to assess whether the QDRR indicated	

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		review by the medical provider. The QDRR indicated review by the medical provider in six out of six examples (100%). • The QDRR indicated review by the psychiatrist in one out of the five examples (20%) of the QDRRs that required review by the psychiatrist. One example did not include psychotropic medications. • The completed MOSES and DISCUS were included as part of the assessments for the QDRRs in 5 out of 6 (83%) examples. There was no MOSES provided for Individual #108. • The IRRFs reflected side effects in 12 out of the 12 examples (100%). • By review of the annual medical assessment, clinical laboratory data, clinical consultations, and other diagnostics, the Monitoring Team concurred with the pharmacists that no specific recommendations were required on 12 out of 12 QDRRs (100%). • There were no examples that included drug use for osteoporosis • The QDRR clearly delineated effectiveness of all drugs prescribed in zero out of 6 examples (0%) The following are some additional comments, and concerns noted from this review: • Individual #81: The two QDRRs provided for this example indicated that QDRRs were not completed timely. For example, the most recent QDRR was dated 9/9/2013, while the previous QDRR was completed on 3/12/2013; hence, there was a six-month interim between QDRRs. The previous QDRR indicated a review date of 3/12/2013, which was completed 8 months following the QDRR before that, dated 7/12/2013. The Monitoring Team noted that the QDRRs were not completed quarterly. The ISP dated 6/11/2013 indicated that Zyprexa was discontinued because of the diagnoses of diabetes and metabolic syndrome, and the individual was started on Seroquel. The most recent QDRR, dated 9/9/2013 indicated that the Individual was on Zyprexa, and not on Seroquel. The medication list provided, dated 9/9/2013 indicated that the Individual was started, but then discontinued from Seroquel, and re-started on Zyprexa. Neither the IRRF, or updated IRRF, documented the rationale for switching back to Zyprexa from Seroquel, or related risks associated with the use of Zyprexa in an Individual with multiple metabolic risk factors and diabetes. The IRRF did not discuss the issue of metabolic syndrome under the heading of diabetes, and the IRRF did not discuss medication side effects under a specific heading for polypharmacy/side effects. • Individual #46: The current QDRR was completed on 8/28/2013, and the previous QDRR was completed on 5/1/2013, which was over the three month quarterly assessment period. Also, the QDRR completed on 5/1/2013 was completed five months following the 12/10/2013 QDRR; hence, the Facility was	

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		not completing QDRR's within a quarterly period. The Monitoring Team was pleased to see that the elevated QTc issue was addressed as part of the IRRF; however, the pharmacist should have also commented on the QDRR and the IRRF of the known risk factors associate with metabolic risks, such as the diagnosis of hypertension, and the prescribed neuroleptic medications. • Individual #51: The current QDRR, dated 10/7/2013, was completed five and one-half months following previous QDRR, dated 4/25/2013; therefore, the QDRR was not completed within a quarterly period. There was no specific comment or recommendation as to the Individual having a diagnosis of hypertension, meeting two criteria for metabolic syndrome, and being prescribed a neuroleptic. • Individual #2: The current QDRR documented a clinically appropriate review of anticholinergic drug usage. The IRRF and the QDRR did not document risks associated with medications. For example, the Individual was on several pro-constipating medications, including haloperidol, and is prescribed three medications for constipation. The IRRF and the QDRR did not assertively document the pro-constipating effect of two neuroleptics, and other anticholinergic medications prescribed. • Individual #127: The QDRR dated 8/28/2013 was completed within three months from the previous QDRR, dated 5/28/2013; however, the QDRR dated 5/28/2013 was completed five months following the 12/12/2012 QDRR, which was outside of the quarterly review period. The Individual was on two neuroleptics, and the QDRR did not address appropriateness of the concomitant administration of two neuroleptics. There were no specific comments for the use of anticholinergic drugs, despite being on anticholinergics. The QDRR did not comment on the clinical appropriateness of the scheduled dosing of the prescribed benzodiazepine. Conclusion: The Monitoring Team determined that the Facility was not in compliance with Section N.2, and must continue to enhance it's QDRR process by ensuring that QDRRs are completed at least quarterly; documenting the appropriateness of all medications prescribed; and ensuring that the psychiatrist reviews, signs, and acts upon QDRRs that include the use of medications for psychiatric indications.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist	Provision N.3 requires that the Facility evaluate its process and usage of stat emergency medications, polypharmacy, benzodiazepines, anticholinergics, and metabolic syndrome. The following is the Monitoring Team's review of Facility's processes for monitoring these medication related issues:	Noncompliance

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	shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	<u>Benzodiazepine usage:</u> The Monitoring Team requested the following documents to review the Facility's review of benzodiazepine use: • Alpha list of all individuals on a benzodiazepine • Data analysis and committee meeting minutes reflecting the Facility's systems review for benzodiazepine use • For the first five individuals on a list of benzodiazepines used for psychiatric indication, and first five individuals on a list of benzodiazepines used for neurological indication: o Most recent two QDRRs o Most recent IRRF o Current medication list o Most recent psychiatric assessment o Most recent annual medical assessment <u>Assessment of Benzodiazepine usage</u> Based on review of the clinical documents, per the document request, the Monitoring Team made the following determination, for the eight examples provided by the Facility (Individuals #77, #79, #11, #55, #19, #15, #127, and #145): • In eight out of eight cases (100%), the QDRR documented the use and indication for the use of the benzodiazepine. • In one out of eight cases (13%), the QDRR documented risks associated with the use of the benzodiazepine; however, review of associated IRRFs indicated that zero out of eight examples (0%) commented on risks associated with benzodiazepine. The statement of risks could be more comprehensive. The Monitoring Team suggests it is important to comment on specific risks associated with the use of benzodiazepines. Paradoxical agitation, cognitive decline, and fall risk are all important risks that should be clearly understood by the IDT, delineated on the QDRR, and considered in developing the IRRF. • In one out of eight examples (13%), the QDRR documented efficacy or lack of efficacy for the benzodiazepine. • In one out of eight examples (13%), the QDRR documented recommendations for continued use, along with the clinical rationale for continued use, or consideration for alternative treatments. An incidental finding upon review of QDRRs, is that only one out of eight examples (13%) was completed within a quarterly time period. Also, the previous QDRR was noted to be significantly delinquent in seven, out of eight examples (88%). Summary:	

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		The Facility must ensure timely completion of QDRRs. The Monitoring Team recommends that the pharmacy document a complete review for the use of any benzodiazepine, that includes indication, associated risks, efficacy or lack of efficacy, and clinical appropriateness for use. <u>Review of Anticholinergic Usage</u> To assess the Pharmacists' participation in the monitoring of anticholinergic drug usage at the Facility, the Monitoring Team requested the following documents: • Past six-months committee meeting minutes, demonstrating a systems review for the Facility's usage of drugs with anticholinergic properties • Data, graphs, and data-analysis specific for the pharmacy's monitoring of the use of drugs with anticholinergic properties • Alpha list of individuals who are prescribed anticholinergic drugs • For the first ten individuals on the list of individuals prescribed anticholinergic drugs (Individuals #) o Most recent two QDRRs o Current medical list o Most recent medical, and psychiatric annual reviews o Most recent MOSES and DISCUS assessments The Facility provided a list entitled "Anti-Cholinergics Report", however, the report indicated only the individuals who were prescribed Cogentin, and no other medications with anticholinergic properties. In this example, Zyprexa was prescribed for a psychiatric indication, and this drug is known to have anticholinergic properties. The Facility must review individuals who are prescribed medications that have anticholinergic properties. This level of review is important, because of the additive nature of anticholinergic side effects. The following is a summary of the pharmacy's clinical review of anticholinergic medications during the QDRR process for Individuals #59, #2, #15, #67, and #97: • In zero out of five examples (0%) the QDRR documented the indication for the use of all anticholinergics prescribed. The Facility did indicate the indication for the benztropine in two out of five examples (40%). The Facility must identify, and assess for the use of all drugs with anticholinergic properties. • In one out of five cases (20%), the QDRR documented risks associated with the use of anticholinergics. The QDRR for Individual #97 indicated that close monitoring was required because the individual was prescribed "haloperidol, Cogentin, and quetiapine, and have additive anticholinergic effects". • In one out of five examples (20%), the pharmacist documented the efficacy, or lack of efficacy, for the use of anticholinergics.	

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		Summary: The Facility must identify, assess, and report on all drugs with anticholinergic properties. This is important because of the additive effects of anticholinergic drugs. The Pharmacist must also document all known, and potential side effects associated with the use of anticholinergic drugs. The pharmacist must make an independent clinical assessment as to the appropriateness of use of anticholinergic drug usage. <u>Review of polypharmacy usage</u>: To review the pharmacists' participation with assessing the appropriateness of polypharmacy, the Monitoring Team reviewed the following documents: • POMC meeting minutes for 10/17/2013 • List of all individuals on polypharmacy • For the first five individuals on the list of polypharmacy (Individuals #145, #149, #127, #97, and #59): o Most recent two QDRRs o Most recent psychiatric assessment o Current medication list o Most recent ISP, or related document the use of polypharmacy The following is a summary of the documents reviewed for polypharmacy: • In five out of five examples (100%) the QDRR documented the indication for the use of each drug associated with polypharmacy. • In zero of five examples (0%), the QDRR documented serious risks for the use the polypharmacy combination. The QDRR did not list specific potential side effects, and other potential consequences, such as drug-drug interactions, that should be closely monitored. Within the context of a developmental center, all known, and possible risks associated with prescribed medications must be made well aware to other IDT members, by ensuring that relevant risks for prescribed medications are documented on the QDRR, and on the IRRF. The QDRR should provide other IDT members an understanding of the risks associated with the prescribed polypharmacy, and that was not clearly delineated. • In zero out of five examples (0%), the current IRRF assessment documented risks associated with polypharmacy. • In two out of five cases (40%), the QDRR documented the use of polypharmacy was clinically justifiable, or provided recommendations for alternative, dosage or treatment. The QDRR must document recommendations for each medication associated with polypharmacy. • In three out of five cases (60%), the pharmacist documented the efficacy, or lack of efficacy for the use of polypharmacy. The QDRR should document the efficacy,	

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		or lack of efficacy for the polypharmacy. This also was not discussed in the last report and will be reviewed for compliance at the next visit. • In zero out of five examples (0%), the current IRRF assessment documented risks associated with polypharmacy. As reported for Section J.11, of this report, the Monitoring Team was extremely impressed with the Facility's robust and effective polypharmacy committee process. The review assessed polypharmacy at both the system, and individual level by ensuring appropriate diagnosis, targeted behaviors, appropriateness of polypharmacy, and providing relevant recommendations to the prescribers of polypharmacy. The reader is referred to Section J.11 for additional details regarding the Facility's review of psychotropic polypharmacy. The QDRR must be completed at the same level of comprehensiveness, and the IRRF must include the risks and appropriate actions. Summary: The pharmacist must provide a clinical opinion as to the rationale and appropriateness of the polypharmacy, document all known and potential risks associated with the prescribed polypharmacy, and provide clinical recommendations regarding dosage, and alternative treatment, when clinically appropriate. The IRRF must include a comprehensive assessment for polypharmacy, and for potential risks associated with the use of polypharmacy and psychotropic medications in general. <u>Review of STAT Chemical Restraint usage</u>: The Facility reported no usage of stat chemical restraint, therefore the Monitoring Team did not assess stat chemical restraint for this Section. It should be noted that the Self-Assessment for Provision N3 stated, "when an emergency chemical restraint for behaviors was needed, reviews for the events were conducted to ensure clinical appropriateness". In this case, the Monitoring Team was informed that there were no chemical restraints administered during the time frame that was assessed. The self assessment for Section N.3 also indicated that "There were seven Chemical restraints from 04/2013 through 09/2013. Audit data supports the events were appropriately addressed and documented." This brings into question the data provided. <u>Assessment of Metabolic Syndrome Monitoring:</u> The Monitoring Team selected the first five and last five individuals on a list of all individuals that are on a neuroleptic and had a diagnosis of diabetes or hypertension, and reviewed the following documents to assess the Facility's monitoring of metabolic syndrome. Nine of the ten requested examples were provided (individuals #77, #76, #150, #15, #3, #123, and #134. • Most recent QDRR	

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		• Most recent IRRF • Current medication list • Most recent six months laboratory data • Most recent annual medical assessment • Most recent psychiatric assessment • Most recent ISP or addendum to the ISP documenting risk for metabolic syndrome The following is a summary of the documents reviewed for metabolic syndrome, for the seven examples provided (individuals #77, #76, #150, #15, #3, #123, and #134): • Nine two of seven QDRRs (29%) indicated specific review for metabolic syndrome on the QDRR report. It should be noted that six out of seven examples (86%) indicated a review for metabolic syndrome on the associated QDRR worksheet; however, there was no statement on the worksheet if metabolic syndrome was present or not present. The Facility must document a review of metabolic syndrome on all QDRRs, when medications are prescribed that are known to cause metabolic syndrome. • Two out of seven QDRRs (29%) assessed clinically appropriate risk factors to evaluate for metabolic syndrome. The associated QDRR worksheet demonstrated review of relevant risk factors in six out of seven examples (86%); however, the pharmacist must document the evaluation on the QDRR for the medical providers to review. The Monitoring Team noted that the work sheet used by the pharmacist for metabolic syndrome did not assess if an individual had a diagnosis of a medical condition that is known to be associated with metabolic syndrome, such as hypertension, hyperlipidemia, and diabetes, and ensure that that medical condition is counted as an actual risk factor, when assessing for metabolic syndrome. • The associated IRRF documented a specific risk assessment for metabolic syndrome in zero out of seven examples (0%). The IRRF must document associated risks of medications that are known to cause metabolic syndrome, especially when an individual has diabetes. • The Pharmacist discussed the risk benefit for either continuing or discontinuing the medication associated with metabolic risk in zero out of nine examples (0%). The Monitoring Team noted that the QDRR for Individual #77 was dated 5/3/2013, and the previous QDRR was dated 6/26/2012. Both QDRRs were well outside of a required quarterly review period. Also, Individual #123 was admitted to the Facility on 6/10/2013, and at the time of this review, a QDRR was not completed. Summary	

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		The Facility must ensure that for all individuals who are prescribed drugs that are known to cause metabolic syndrome, that there is a well documented review for metabolic syndrome on the QDRR; pharmacist's recommendations to help mitigate metabolic syndrome, when clinically appropriate; and pharmacist's indication of risks, and benefits associated with drugs known to cause metabolic syndrome. Also, the IRRF must clearly document the associated risks of such drugs, with regard to metabolic syndrome. <u>Systems review for anticholinergic, benzodiazepines, polypharmacy, and metabolic syndrome</u> P&TC meeting minutes dated 10/17/2013 indicated a cursory review of benzodiazepine use by indicating that "trend lines for both benzo's and anticholinergic use is rising. The reason for the higher rising usage was impacted by stat/once orders". The action plan was to "revise report for next meeting". The minutes did not reflect a systems review for indications, such as psychiatric, neurological, sleep aid, and restraint, or delineation of specific trends, such as types of benzodiazepines, associated adverse outcome, and analysis of efficacy. The only data elements provided for review were graphs associated with usage and dosage of Benztropine, and anticholinergics. P&TC meeting minutes dated 10/17/2013 indicated a review of metabolic syndrome. The minutes reflected that 17 individuals were screened for metabolic syndrome, and that six out of the 17 met criteria and/or are diagnosed with metabolic syndrome. The minutes continued by stating "this report (Metabolic Syndrome) after today will be discontinued. It is not necessary to continue reporting." The action plan, however, stated "No action needed. On-going monitoring". The system review of metabolic syndrome did not review associated pharmacological risk factors. Summary: The Facility performs excellent systems review of psychotropic polypharmacy, but the QDRRs are not as comprehensive or complete. Furthermore, additional enhancement is needed with regard to systems review of benzodiazepine, anticholinergic, and metabolic syndrome. Data elements, at the individual and system level, should be regularly collected, trends analysis completed, and review by appropriate committee structure, with recommendations to improve systems, and clinical outcome, as necessary. Conclusion: Review of QDRRs indicated significant delay in completing QDRRs within the quarterly time frame. The Facility must immediately address this delay. The Facility must also enhance the QDRR process with regard to its review of polypharmacy, benzodiazepine, and anticholinergic drug usage, and review of metabolic syndrome. The Facility performs excellent systems and individual review of polypharmacy, but systems review of metabolic syndrome, and benzodiazepine, and anticholinergic drug usage must be	

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		improved. For example, the pharmacist must ensure that a review of metabolic syndrome is well documented on the QDRR when ever there is a drug prescribed that is known to cause metabolic syndrome. The pharmacist must document agreement or disagreement with the indication, appropriateness, and dosage of benzodiazepine, anticholinergic, and polypharmacy related drugs, and provide specific clinical recommendations to minimize the use of these drugs, when clinically appropriate. The Facility must include its review of anticholinergics, but including all drugs with anticholinergic properties, not just Cogentin. Because of these findings, the Monitoring Team determined that the Facility in not in compliance with Section N.3.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	To assess the pharmacist's clinical recommendations, and clinical appropriateness of the medical providers' response to the recommendations, the Monitoring Team assessed the QDRRs for Individuals, #59, #2, #15, #67, #97, #77, #79, #11, #55, #19, #127, #145, #108, #81, #46, and #51). The following is a summary of the QDRRs reviewed: • In 16 out of 16 examples (100%), the treating medical provider signed and dated the QDRR, indicating a review by the medical provider. • In 16 out of 16 examples (100%), the medical provider indicated either accepting or rejecting the pharmacist's recommendation by checking agree or disagree next to each recommendation. • In zero out of 16 examples (0%) did the psychiatrist indicate review of the QDRR, when prescribed a psychotropic medication. The Monitoring Team did not request, and the Facility did not provide, Single Patient Drug Intervention documents. The Monitoring Team will review those at the next compliance visit. Summary: The psychiatrist did not indicate review of the QDRRs, and did not indicate either agreement, or disagreement with the pharmacist's recommendation; this was a regression compared to findings at the last compliance visit. Other requirements were met. The Monitoring Team will continue the rating of substantial compliance at this time. The Facility must ensure that for all QDRRs that include review of a psychotropic medication, or other medications used for a psychiatric indication, the psychiatrist must review and sign the QDRR, and ensure that the pharmacist's recommendations are agreed or disagreed upon, and indicate a clinically relevant action plan when the recommendations are not agreed upon.	Substantial Compliance
N5	Within six months of the Effective	To assess the Facility's ability to ensure clinically appropriate drug monitoring of tardive	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	dyskinesia, the Monitoring Team reviewed regularly scheduled MOSES and DISCUS assessments and assessments following changes in neuroleptic medications. The Monitoring Team reviewed a total of 26 MOSES and 18 DISCUS assessments provided for Individuals #59, #2, #15, #67, #97, #77, #79, #11, #55, #19, #127, #145, #108, #81, #46, #51, #60, #72, #36, #13, and #44: • In 26 out of 26 MOSES assessments (100%) there was evidence that the prescriber signed, dated, and completed the physician component of the assessment tool. • In 17 out of 18 DISCUS assessments (94%) there was evidence that the prescriber signed, dated, and completed the physician component of the assessment tool. The Monitoring Team requested all MOSES and DISCUS assessments completed for the first ten individuals, beginning in 5/1/2013, following either a dose increase of a prescribed neuroleptic, or if a new neuroleptic was initiated. The following is a summary of the Monitoring Team's review of the MOSES and DISCUS assessments provided for review. (The Facility provided only five of the ten examples requested, for Individuals #60, #72, #36, #13, and #44): • More frequent monitoring for tardive dyskinesia was noted in one out of five examples (20%): o Individual #60: Only one, a baseline MOSES, was provided for review. There was no evidence of increased monitoring with MOSES and DISCUS. o Individuals #131, #44, and #72: Only MOSES assessments were provided, and in no case was there evidence of more frequent monitoring to assess for emergence of side effects secondary to an increase change of a neuroleptic. o Individual #36: There was increased monitoring with both MOSES and DISCUS assessment tools following dose increase of a neuroleptic. Conclusion: Although the prescriber signed, dated, and completed the prescriber component of the assessment tools, the Facility did not perform more frequent monitoring for emerging side effects secondary to a dose increase, or addition of a new neuroleptic. At the last compliance visit, the Monitoring team found that the Facility was completing this more frequent monitoring. For this reason, the Facility did not remain in compliance with Section N.5.	
N6	Commencing within six months of	To assess the Facility's adverse drug reaction (ADR) process, the Monitoring Team	Noncompliance

#	Provision	Assessment of Status	Compliance
	the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	requested the following documents: 1. List of all ADRs that occurred during THIS reporting period a. Name of individual b. Type of ADR c. Date ADR occurred d. Date ADR initially reported 2. Copy of all data, data analysis, and past six months committee meeting minutes documenting a SYSTEMS review specifically for ADRs at the Facility 3. Copy of policy/procedures specific to staff training on ADRs 4. List of all staff who have received specific training on identifying, and reporting of ADRs for each group (please be specific) a. Direct care support staff b. Pharmacists c. Nurses d. Medical prescribers e. Other 5. List of all staff who have not received specific training on identifying, and reporting of ADRs a. Direct support professionals b. Nursing c. Pharmacists d. Medical prescribers e. Other 6. For the first, and every second, ADR reported during this review period, for a total of ten ADRs: a. Copy of all ADR related forms completed b. Copy of IPNs documenting medical provider's initial examination/review of the individual for the reported ADR (must include a clinical action plan for follow-up to the ADR) c. Copy of all medical orders specific to the ADR (such as d/c medication, alternate medication, laboratory studies, etc) d. Copy of all related nursing IPNs specific to the ADR and monitoring of the ADR e. Copy of the pharmacist's review of the ADR, and recommendations f. Copy of the IDTs notification of the ADR (including notification to the guardian) The Facility did not provide a policy or procedure specific to an ADR process. The Facility indicated that one ADR was reported during the past six months; the ADR report was illegible, and additional information requested, including IPNs, physician orders, and pharmacist's review was not provided; hence the Monitoring Team was unable to review	

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		the document for completeness and clinical appropriateness. The Facility did not provide trends analysis and committee meeting minutes demonstrating the Facility's systems review of ADRs. The Facility indicated that a total of 21 staff were trained on reporting of ADRs, but there was no list indicating staff who still required training. Because the Facility did not have a policy and procedure for its ADR process; did not provide a list of staff who still required ADR training; did not have an effective mechanism to track and trend ADRs; and did not provide the requested documentation for the one ADR reported, the Monitoring Team determined that the Facility was not in compliance with Section N.6.	
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 development and provision of drug utilization evaluations (DUEs) the Monitoring Team requested the following information: • Complete DUE schedule for 2013 and 2014, to include all DUEs provided and pending • Copies of all DUEs provided during the reporting period <u>DUE Schedule:</u> The Monitoring Team was provided a typed list of DUEs, that were reported to have been either completed or in-progress: • Clozaril 12/1/2012 • Ziprasidone 3/1/2013 • Fluxetine 6/1/2013 • Coumadin 8/29/2013 • Benzropine 10/13/2013 The list did not indicate if the DUE was completed. A typed list labled "DUE Calendar Next 4 QTRS" was provided: • Anticholingeric – Benztropine FY14 Q1 • Benzodiazepines – Lorazepam FY14 Q2 • Beta Blockers for psychotropic usage – Metoprolol FY14 Q3 • Atypicals – Clozapine (Clozaril) FY14 Q4 There was no list of DUEs provided for FDA advisories. <u>Review of completed DUEs:</u> The Facility provided a stack of many documents that were not separated into specific DUEs. The Monitoring Team identified two Medication Summary Reports, which listed the number of medications evaluated, common indications, contraindications addressed, patient monitoring parameters, and dosage guidelines.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Medication Summary Report for ziprasidone: The report indicated that 12 medications were evaluated and that 100% were prescribed for appropriate clinical conditions; contraindications were addressed in 83% of the examples; 100% were prescribed within dosage guidelines; and 58% were appropriately monitored by the prescribing physician. At the bottom of the report was a statement "Reviewed 4pt, over 3 months gives you 12 opportunities for modifications". The Monitoring Team could not determined the clinical relevance of this DUE, or what recommendations were made for prescribers to consider. There was no indication that a specific action plan was developed, or tracked for completion and efficacy. In addition to the Medication Summary Report, there were Drug Audit Checklists for the 12 cases that were reviewed. The checklists included specific items for the pharmacist to review, including indication, monitoring parameters, appropriate dosing, and contraindications. • Medication Summary Report for fluoxetine: The report indicated that 3 medications were evaluated and that 100% were prescribed for appropriate clinical conditions; contraindications were addressed in 33% of the examples; 100% were prescribed within dosage guidelines; and 100% were appropriately monitored by the prescribing physician. At the bottom of the report was a statement that provided a brief overview of the pharmacist's findings, and some recommendations for prescribers to consider. There was no indication that a specific action plan was developed, or tracked for completion and efficacy. There were no Drug Audit Checklists provided for review for this DUE. A typed report labeled "Coumadin DUE Summary" was identified and reviewed by the Monitoring Team, and included drug audit checklists for three individuals; however, there was no Medication Summary Report included for review. The document provided indicated a review of the medication usage for three individuals, and included a detailed analysis of clinically relevant monitoring parameters, and the pharmacist determined that in all three cases the medications were managed appropriately; hence, there were no recommendations by the pharmacist. There were no Medication Summary Reports, or Drug Audit Checklists provided for the scheduled DUE to review benztropine. <u>FDA advisories:</u> The FDA issued many advisories during the six-month reporting period, and the Monitoring Team was provided a printout list issued by the FDA of its advisories that occurred during the reporting period. There was no specific documentation provided by the Facility of its issuance, or of a review process for FDA advisories. The Facility must ensure that medical providers and pharmacists are provided specific in-service materials for DUEs developed for FDA advisories, or other forms of informational materials for	

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		specific classes of drug that are commonly used in general medicine and psychiatry, but not currently utilized at the Facility <u>Medical provider and pharmacists training on DUEs</u> There was no evidence to indicate that medical providers and pharmacists were provided in-service training, or provision of training materials specific to completed DUEs. <u>Review of P&TC meeting minutes</u> One set of P&TC meeting minutes were provided, and dated 10/17/2013, and included only a very cursory overview of the findings of the DUE for fluoxetine, with no indication if system improvements were necessary or not; and a brief statement related to the DUE for Coumadin, stating "the same two patients on Coumadin for the 4th Qtr. Everything is normal. All patients in therapeutic range". The associated DUE for Coumadin, however, indicated that there were three individuals on Coumadin, who were assessed by the DUE. Conclusion: The Facility did not provide information on the scheduled DUE for benztropine, and did not use a unified process to evaluate drug usage. For example, the Facility utilized a Drug Audit Checklist for Coumadin and ziprasidone, but not for fluoxetine, and the Facility completed a Medication Summary Report form for fluoxetine and ziprasidone, but not Coumadin. The Facility did not maintain a formal calendar to track all DUEs, which is important because a calendar would enable efficient review of all DUEs provided, pending, and completed, and enable the Facility to periodically reassess DUE related issues. There was no evidence to indicate that the Facility had a dedicated process to track pharmacist's recommendations for DUEs through completion, and to assess the efficacy of recommendations. There was no indication that medical providers were provided in-service materials related to the completed DUEs, and review of the one set of P&TC minutes provided for review only included a very cursory overview of the findings of the DUE for fluoxetine, with no indication if system improvements were necessary or not. The P&TC minutes also included a statement related to the DUE for Coumadin, stating "the same two patients on Coumadin for the 4th Qtr. Everything is normal. All patients in therapeutic range". The associated DUE for Coumadin, however, indicated that there were three individuals on Coumadin, and were assessed by the DUE. There was no documentation indicating that DUEs were developed for FDA advisories. The Facility must ensure that medical providers and pharmacists are provided a specific in-service materials for DUEs developed for FDA advisories, or other forms of informational materials for specific classes of drug that are commonly used in general medicine and psychiatry, but not currently utilized at the Facility. The Monitoring Team determined that the Facility is not in compliance with Section N.7, and strongly encourages that the Facility to enhance its DUE process.	

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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 requested the following documents: • Policy and procedures specific to medication variance (especially reporting of medication variances) • All data, trends analysis and last six months committee meeting minutes specific to the Facility's system review of all medications variances that occurred during the reporting period • List of all medication variances that occurred during the reporting period • For the current reporting period), please provide o Data, data analysis, and all related committee meeting minutes specific to the review, analysis, and improvements necessary for drug reconciliation issues (such as drug over usage) • For the first and then every third individual on the list of medication variances, for a total of ten examples, please provide: o Copy of medication variance reporting forms o All physician IPNs associated with the medication variance o All nursing IPNs associated with the medication variance (initial assessment, and through the monitoring period for the medication variance) o All pharmacy documentation, and communication related to the medication variance o All IDT minutes specific to the medication variance o Documentation that the guardian was made aware of the medication variance (for category C or worse) <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. 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. No other policies or procedures were provided for review for this Section. <u>Review of medication variance data (per Section M.8 of this report)</u> The chart below shows the overall number of medication variances reported from March 2013 through September 2013, by number of total medication variances reported for La Paloma and El Paisano. In addition, the chart shows the number of medication variances by responsible disciplines:	Noncompliance

#	Provision	Assessment of Status	Compliance

Medication Variances

Month and Year	La Paloma	El Paisano	Nursing	Pharmacy	Total
March 2013	8	8	15	1	16
April 2013	4	2	5	1	6
May 2013	8	1	9	0	9
June 2013	0	1	0	1	1
July 2013	0	0	2	0	2
August 2013	4	1	5	0	5
September 2013	9	4	5	8	13
Total	35	17	41	11	52

Attached to the above data was the FY2013 Facility Wide (Mental Health and ICF-IDD) Medication Variances by Month for Inpatient Services data, prepared 10/17/13 for presentation to the Pharmacy and Therapeutic Committee. The data in the charts were represented in tabular charts, linear graphs, bar graphs, and pie charts with accompanying text boxes and/or narrative explanations describing the data both in general terms, as well specific to either Mental Health or IFC-IID and some proposed measures to implement to reduce and/or prevent the incidences of medication variances. A narrative explanation stated there were no medication variances committed by the medical discipline. This statement was questionable because the medical discipline is just as likely to commit medication variances as the nursing and pharmacy disciplines. More attention should be paid to analyzing medication variances for the medical discipline to ensure they are reporting their medication variances and are taking appropriate corrective actions.

The only monthly Medication Management Workgroup Notes provided since the last compliance review was for 7/23/13. The cover sheet requesting TX-RG1311-X12.f, for the last six months of the Medication Error/Variance Committee minutes stated, "Not applicable, refer to P & T Committee." However, the only Pharmacy and Therapeutics Sub-Committee Meeting Minutes provided since the last compliance review was for 6/26/13. Only the agenda for the 10/17/13 Pharmacy and Therapeutics Sub-Committee Meeting was provided for review. The Medication Management Workgroup Meeting scheduled for 11/21/13, during the compliance visit was canceled. Therefore, the status of issues reviewed, discussed, and decisions made regarding current medication management practices, including corrective actions and their effectiveness in reducing and/or preventing medication variances, could not be determined.

<u>Review of individual medication variance reports, and related follow-up documentation</u>
The Facility did not provide copies of specific medication variance reports, and did not provide IPNs by the medical provider or nurse, who evaluated the Individual following

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		report of a medication variance. Conclusion. The Facility requested limited review of Section M.6, because of self identified lack of improvement in the area of medication variance. Sections, N.8, and M.6 are closely linked, and therefore the Facility's report of lack of improvement for Section M.6, can be extrapolated to Section N.8. For its review of Section N.8, the Monitoring Team noted that the Facility's primary policy for medication variances had not been updated since 2007, and this concern was commented on in the last report. The Facility provided a set of committee meeting minutes for the Medication Management Workgroup meeting, dated 7/23/2013, and P&TC sub committee meeting minutes, dated 10/17/2013. The workgroup meeting minutes delineated relevant data; however, there were no examples of the data being analyzed and trended sufficiently to identify systemic trends in order for the Facility to take meaningful and sustaining corrective actions. The Facility did not provide copies of completed medication variance reports. The Monitoring Team was also concerned because the report did not include a data field for medical services. The Monitoring Team determined noncompliance for Section N.8, and strongly recommends that the Facility enhance its medication variance process by ensuring that medical providers are closely monitoring for medication variances; that all relevant staff, including pharmacists, nurses, and medical providers are well trained on reporting of medication variances; that the Facility medication variance process is delineated within the context of current policies and procedures; that comprehensive, and meaningful analysis of medication variance data is done, that includes trend analysis; that all relevant staff, including nurses and medical providers, follow-up on each reported medication variance, and document their physical assessment of the individual in an IPN; that action plans are developed, with specific follow-up to completion, and assessment of efficacy of the action plan; and that P&TC members conduct comprehensive review of medication variances.	

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-Assessment, dated 11/6/2013 2. RGSC Action Plan 11/5/2013 3. RGSC Policy 500-02 Physical and Nutritional Management Policy (rev 4-2013) 4. PNMP Monitoring Process (9/1/2013) 5. Settlement Agreement Monitoring Tool for Section O Record reviews: 6. Sample O.1: Individuals #19, #48, #51, #60, #72, #118, #126, #134, and #140 7. Sample O.2: Individuals #4, #15, #19, #35, #40, #65, #126, and #150 8. Sample O.3: Individuals #19, #79, and #126 9. Sample O.4: Individuals #19, #77, #81, #97, #98 #115, #118, and #149 10. 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 were admitted to the hospital since the last compliance visit with admitting and discharge date and diagnosis g. Who were diagnosed with pneumonia or a respiratory difficulty since the last compliance review (include date and type) h. With falls in the last 12 months (date, location , type of injury)* i. With chronic respiratory infections j. With chronic dehydration k. With fecal impaction l. With pressure ulcers in the last 12 months (date, location and resolution) m. With fractures in the last year (date, location of fracture, status) n. Who were non-ambulatory or require assisted ambulation o. With wheelchairs for primary mobility p. With wheelchairs for transport q. Who use Assistive Devices for ambulation (type of device) r. With orthotic/braces 11. New PNMT members since last review, including a copy of their curriculum vita; 12. Caseloads of PNMT dedicated and non-dedicated members. 13. 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. 14. QA reports/matrix since the last compliance review 15. List of referrals to the PNMT since the last compliance visit 16. PNMT RN post hospitalization assessments completed since the last compliance visit 17. PNMT assessment template 18. PNMT Action Plan template 19. IRRF template 20. IHCP template 21. Compliance Monitoring Form guiding questions sheet 22. List of new employees since last compliance visit and their PNM related performance check offs 23. 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) 24. Facility documentation showing categories of staff requiring annual refresher training, numbers of staff requiring training, and numbers of staff who have successfully completed training; 25. PNM Monitoring Tool template 26. Last three months of PNM monitoring data (including date, activity monitored, time of monitor, person conducting monitor) 27. For Individuals in Samples 0.1 to 0.3: a. All ISPs in the last 12 months b. All ISPAs in the last 12 months c. All IRRFs in the last 12 months d. All IRRF Action Plans in the last 12 months e. IHCP/Action Plan f. QDDP Monthly Reviews for the last 6 months g. Braden Scale forms h. Annual weight graph i. Nutrition tab, including assessments and reviews j. Head of Bed Elevation (HOBE) assessments k. PNMT assessments and any other PNMT documentation other than IPNs in the last 12 months, if not already submitted l. OT/PT assessments in the last 12 months m. SLP assessments, including Communication/AAC in the last 12 months n. 6 months IPNs o. Trigger sheets completed in the last 6 months, including the current one p. PNMPs in the last 12 months, including pictures q. Dining Plans in the last 12 months, including pictures r. Completed PNM-related monitoring sheets in the last three months s. Evidence of effectiveness monitoring completed within the last six months t. Aspiration Pneumonia Enteral Nutrition (APEN) in the last 6 months u. 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) v. Direct intervention plan and supporting documentation for implementation of the plan (i.e., monthly progress notes) w. Individual notebooks (PNM section) **People Interviewed:** 6. Jane Augustine PT Director of Habilitation Services 7. Belinda Lopez SLP 8. Betty Perez Rehab Tech II 9. Marcy Valdez RN 10. Six direct care staff (3 La Paloma, 3 El Paisano) **Meeting Attended/Observations:** 1. PNMT meeting 11/19/13 2. Morning Medical meeting 11/20/13 3. Mealtimes and Transitions (La Paloma, El Paisano)
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, dated 11/6/13, and Action Plan dated 11/5/13. 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 identify not having a consistent OT as a negative finding or measure participation as a single indicator as does the metric utilized by the Monitoring Team. 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 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 being in compliance with Provisions O.1, O.2., O.3, O.6, O.7, and O.8. This was inconsistent with the Monitoring Team's findings of noncompliance with all provisions. The Action 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: RGSC requested a streamlined review of Provisions O.4 and O.6 with the understanding that these provisions would not be measured for substantial compliance. Upon arriving at the Facility, the Facility had not drawn a sample and was unsure as to what they wanted the review to focus on. A limited sample was drawn and all metrics were applied. 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 had shown improvement in clear analysis of the reason for referral as well as providing a clear framework for identifying the assessments needed to revise current plans of care and thus mitigating the risk associated with the referral. The monitoring system, while more formal, remained unclear regarding the criteria in which individuals received certain levels of monitoring. An overriding concern noted appeared to be a lack of implementation of plans of care. Examples of failing to implement plans went beyond mealtime strategies or positioning recommendations but reached failure to comply with suction tooth brushing recommendations and down-time between tube feedings. These two areas can greatly impact the physical and nutritional safety of the individuals. **Provision O.1:** This provision was determined to be not in compliance. Areas of need included development of a comprehensive PNM policy and more 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 and IHCP that included established thresholds for referral back to the PNMT. **Provision O.3:** This provision was determined to be not in compliance. PNMPs were much improved and were felt to contain the areas needed to address PNM issues. The issue was that PNMPs were not updated in a timely manner and often had information that was not consistent with other plans of care (i.e., IRRFs) **Provision O.4:** The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. 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, it was limited to few staff. **Provision O.6:** This provision was determined to be not in compliance. The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. **Provision O.7:** This provision was determined to be not in compliance. There was not a clear criteria identified as to what placed in the Individual in a specific risk category and therefore received a specific level of monitoring frequency. **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. The IRRF did not provide clinical assessment data to identify an individual's potential to return to oral eating. Assessment for return to oral eating was highly dependent on their completion of a MBSS and was specific to whether the person could currently tolerate versus providing treatment to increase potential to tolerate.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and	The following samples were utilized for Section O: Sample O.1 consisted of a non-random sample of 10 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 management needs.	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 eight individuals. Of the eight individuals, two (Individuals #19 and #126) were assessed, reviewed, and/or tracked by the PNMT over the last six months. Sample O.3 consisted of two individuals at RGSC who received enteral nutrition. Sample O.4 consisted of individuals originally chosen for concerns with Communication skills but were also added to this provision secondary to concerns noted regarding consistency between the IRRF and PNMP. **PNM Policy and Role of the PNMT:** The Facility did not have a comprehensive PNM policy that included all 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; ▪ Assessment process; ▪ Process for developing and implementing PNMT recommendations with Integrated Health Care Plans;	

#	Provision	Assessment of Status	Compliance
		▪ 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: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, o 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), o Identification of monitors and their roles and responsibilities, o 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, o 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 o 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., Morning Medical Report 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). 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	

#	Provision	Assessment of Status	Compliance
		implementation of additional monitoring, as appropriate to measure the resolution of systemic issues. The indicators that were 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. It should be stated that there was evidence of PNMT's involvement in the QA process but no guidelines or policy that noted this inclusion. ▪ Collaboration with Dental to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia. To address this area, the PNMT ensures the PNMP follows the individual and the accepting physician and/or dentist is aware of the PNMP. In order for the Facility to move towards substantial compliance, RGSC should ensure the above components are formalized as part of Facility procedure/guidelines. 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 one OT on staff therefore a backup was not available. Not having a backup resulted in lack of OT participation in the meetings. **<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. **<u>Qualifications of PNMT Members</u>** Five of five core and back up PNMT members (100%) were licensed to practice in the state of Texas. Five of five core and back up PNMT members (100%) had specialized training in working	

#	Provision	Assessment of Status	Compliance
		with individuals with complex physical and nutritional management needs in their relevant disciplines. **<u>Continuing Education</u>** Three of five PNMT staff (60%) 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. Based on review of continuing education/training record for fiscal year 09/01/2012 to 9/30/2013, the following core PNMT members have received continued education units in relation to population as follows:	

PNMT Member	Course Title	CEU Hours
PT	Issues in Evaluation and Treatment of Individuals with developmental disabilities	3
	Functional Strength Training for the Aging Spine	0.6
PNMT RN	Medication Administration for Nurses, Hab Conference	7
	Issues in Evaluation and Treatment of Individuals with developmental disabilities	11
	CPR Basic	2
	BLS for Healthcare Providers	4
SLP #1	Medication Administration for Nurses, Hab Conference	6
	Issues in Evaluation and Treatment of Individuals with developmental disabilities	9.5
	The MBSI mP and Dysphagia Practice: Targeted Intervention Through Standardized Physiologic Swallow Assessment	10
SLP #2	Issues in Evaluation and Treatment of Individuals with developmental disabilities	9.5
	Medication Administration for Nurses, Hab Conference	6
	The MBSI mP and Dysphagia Practice: Targeted Intervention Through Standardized Physiologic Swallow Assessment	10
RD	Dysphagia: A Growing Concern in Healthcare	1
	An overview of The Nutrition Care Process	1
	Live Webinar Quiz: Diabetes & Depression	1

No information was provided regarding whether the OT had completed any continuing education.

<u>PNMT Meetings</u>

Below is the PNMT attendance summary:

#	Provision	Assessment of Status	Compliance

Discipline	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Tot # Mtgs	Total %
# Meetings	5	4	4	5	4	4	5	5	4	40	
PNMT RN/ Alt.	5/5	4/4	4/4	5/5	4/4	4/4	5/5	5/5	4/4	40	100%
PT	4/5	2/4	3/4	5/5	4/4	3/4	3/5	4/5	4/4	32	83%
SLP/Alt	5/5	4/4	4/4	5/5	4/4	3/4	5/5	4/4	4/4	39	98%
RD/Alt	4/5	4/4	4/4	5/5	4/4	3/4	5/5	4/4	4/4	38	95%
OT	2/5	4/4	0/4	0/5	2/4	2/4	1/5	1/5	3/4	15	38%
Total Core Average %											83%

From 1/1/13 to 9/30/13, the PNMT met a minimum of weekly.

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.

The primary concern noted with attendance was the lack of attendance by the Occupational Therapist (OT). RGSC had stated that the OT was available by phone if not present at the meeting but the documentation did not adequately substantiate this statement. RGSC had hired a full time OT in September 2013 so it is hopeful that this issue will be addressed by the next compliance visit as there has already been improvement in attendance since the OT was hired.

In order to move towards substantial compliance, the Facility must ensure that all PNMT members are attending the meetings on a consistent basis.

Forty of 40 PNMT meeting minutes (100%) include documentation of appropriate topics: a) referrals; b) review of individual health status; c) PNMT actions; d) follow-up; 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

#	Provision	Assessment of Status	Compliance
		such issues (e.g., Morning Medical Report 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.	**Identification of PNM risk** Sixty-four of 64 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 did not have 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"). While RGSC did have a database, the system was not formalized that ensured revision of data regarding risk levels. Examples are provided below regarding issues with inconsistency between plans. Thirteen of 25 individuals in Samples O.1, O.2, and O.4 (52%) 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). Issues with risk scores focused on consistency issues between documents as well as accurate identification. Examples in which risk was not accurately identified included: • Individual #98 had a history of right lower lobe infiltrates but was only listed as being at a medium risk of aspiration. • Individual # 35 had a choking event in 9/2013 but was listed as being at a low risk of choking during the 10/8/13 IRRF. • Individuals #15 and #65 had inconsistencies between risk levels on the IRRF and the PNMP. **Physical and Nutritional Management Team Referral Process** 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 morning medical has continued to result in improvement in the ability to identify issues occurring throughout the Facility. Two of two 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. **PNMT Assessment** The Monitoring Team was unable to determine if PNMT assessments/reviews for individuals in Sample O.2 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 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. Based on review of individuals' records who were referred to the PNMT or (Sample O.2), the comprehensiveness of the PNMT assessment components were as follows: • One of two (50%) contained date of referral by the IDT. This information was not contained within the ISPA, ISP and/or PNMT assessment • Two of two (100%) contained a date of assessment. The Monitoring Team could not determine whether this was the date completed or the date 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.	

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		• Two of two (100%) identified the individual's current risk rating(s), including the current rationale. This information was contained within the IRRF, and and/or PNMT evaluation as indicated. • Two of two (100%) included updated risk ratings based on the PNMT's assessment and analysis of relevant data. This information was contained within the 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, 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	

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		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>** 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	

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		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. • RGSC had not provided any Head of Bed assessments and therefore this metric was not reviewed. • 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. **PNMT Follow-up and Problem Resolution** With regard to plan implementation for Individuals in Sample O.2: • In two of two individuals' documentation reviewed (100%), supporting documentation was present to confirm implementation of individuals' action plan within 14 days, or sooner as needed, of the plan's finalization. • In two of the two individuals' plans reviewed (100%), 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. **Individuals Discharged from the PNMT** 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. ▪ One of one individuals' (100%) discharge summary/action plan provided objective clinical data to justify the discharge. ▪ 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	

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		in the PNMT policy. In order to move towards substantial compliance, the facility must develop a process that ensures that discharge recommendations are integrated into the IHCP, 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.	**Identification of Individuals Requiring a PNMP** For the six individuals in Sample O.1, zero of their annual ISPs (0%) noted that the appropriate disciplines were present to approve and integrate the PNMP in the ISP. The SLP attended 100% of the meetings, the OT attended 0% of the meetings, and the PT attended 29% of the meetings. Three meetings were unable to be reviewed due the signed signature sheets not being provided. 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. Ten of 10 PNMPs (100%) 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. **PNMP Format and Content** A review of individuals' PNMPs from Samples O.1 and O.2 found: • PNMPs for 15 of 15 individuals (100%) were current within the last 12 months. • PNMPs for 10 of 15 individuals (67%) included a list of all high-risk levels and individual triggers as indicated. Issues were noted regarding accuracy of risk levels included on the PNMP and consistency between the PNMP and the IRRF. See O.2 for examples. • In 15 of 15 most current PNMPs (100%), there were large and clear color photographs with instructions. • 15 of 15 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 four of four PNMPs (100%) for individuals who used a wheelchair as their primary mobility or in transport, positioning instructions for the wheelchair, including written and pictorial instructions, were provided. • In 15 of 15 PNMPs (100%), positioning was adequately described per the individuals' assessments. The degree of elevation was now included in addition to the use of the chain. This addition allows for the plan to be more readily transferrable to other locations (i.e., hospital and home)	Noncompliance

#	Provision	Assessment of Status	Compliance
		• In 15 of 15 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. • In 15 of 15 PNMPs (100%), bathing instructions were provided. • In 15 of 15 (100%) PNMPs, toileting-related instructions were provided, including check and change. • In 15 of 15 (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 15 of 15 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. • Two individuals (100%) had feeding tubes with limited to no oral intake. Two of two (100%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. • In 15 of 15 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 13 of 13 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. • In 13 of 13 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. • In 13 of 13 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 15 of 15 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. • In 15 of 15 PNMPs (100%), 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. • 15 of 15 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 person communicated as well as how staff should bridge communication. **<u>Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT</u>**	

#	Provision	Assessment of Status	Compliance
		For individuals in Samples O.1, O.2, and O.4 for whom the IDT identified changes needed to be made to the PNMP, ISPA meeting documentation noted for 13 of 25 individuals (52%) that the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. See Section O.2 for examples of risk scores not being updated on the PNMP as indicated by the IRRF. For thirteen individuals for whom the PNMP was revised, there was supporting documentation that 13 of 13 revised PNMPs (100%) had been implemented.	
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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. **Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs** 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, four of 10 individuals' (40%) dining plans were implemented as written. Examples included: • Individual #48 was not provided with cues to take multiple swallows. • Individual #31 was seated close to peers when he should have had increased personal space and was not cued to take liquids during the meal as per his PNMP. • Individual #108 was observed taking multiple sequential sips when the plan called for enough in her cup for only one sip. It should be noted that the atmosphere continued to improve as well as compliance on El Paisano. Most of the issues noted occurred on La Paloma. This improvement may be a result of the increased attention to El Paisano and the reorganization of the dining room process. In an effort to improve the dining experience, RGSC assigned staff specifically to assist in the dining room and staggered the dining times so that fewer individuals were eating at one time. This resulted in a much quieter atmosphere that was conducive to a safer and more focused mealtime experience. Based on observations by the Monitoring Team: • Nine of nine positioning plans for individuals' for Sample O.1 (100%) were implemented as written. • One of one individuals' transfer plans (100%) were implemented as written. Positioning and transfers of individuals in and outside of the dining room was noted to	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>have improved since the last review as no significant issues were noted.

An overall concern was the lack in which plans were implemented. Additional examples were Individuals #19, and # 79. Individual #19 was to receive suction tooth brushing but was not provided this consistently by nursing staff. Individual #79's plan called for three hours between feedings but was at times receiving feedings much closer together. This resulted in the occurrence of triggers (increased coughing). Both of these individuals were considered to be among the more medically fragile individuals at RGSC.

<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 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>6</td><td>5</td><td>83%</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>6</td><td>6</td><td>100%</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>5</td><td>83%</td></tr>
<tr><td>If the individual receives enteral nutrition, how do you determine if he/she is in the correct position?</td><td>6</td><td>5</td><td>83%</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</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</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	▪ 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 Thirty-six of 36 new employees (100%) successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs since the last onsite review. **PNM Core Competencies for Current Staff** One hundred twenty of 120 current staff that require training (100%) successfully completed the current PNM core competencies (i.e., foundational skills) performance check-offs. Three of three 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. **Annual Refresher Training** Upon request, the Facility was able 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 able to verify that staff were adequately maintaining their level of training and education according to the schedule provided.. **Individual-Specific Training** To assess 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 #19 and #126 in Sample O.1 had received training on the latest revision to their PNMP. For Individuals #19 and #126, although requested, no evidence was provided that staff assigned had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills). The Monitoring Team requested information, but RGSC did not provide it. Staff responsible for training other staff did successfully complete competency-based training for the specialized components (i.e., non-foundational skills) of the individuals'	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>PNMPs prior to training other staff on the PNMP/Dining Plan.</td><td></td></tr>
<tr><td>O6</td><td>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.</td><td>The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands.

<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. A new revision to the monitoring form was that they were no longer equally weighted. If staff were observed to not be implementing the plan then this resulted in an automatic noncompliance as opposed to previously when they could not implement the plan and still gain a score indicating compliance. This was a very positive development that should make clear when there are needs for retraining individual staff as well as for retraining staff at a home or shift on foundational skills or individual-specific PNM plans. The next step is to ensure that data from the forms are tracked accurately. This issue is discussed further below under this compliance standard.

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:
• Completed the necessary core training related to PNM
• Were trained on Individual specific strategies
• Successfully completed training on the monitoring forms.

Based on review of compliance monitoring data on specific areas affecting proper alignment and risk of harm, for period of 01/1/013 to 10/05/13, results are:

<table>
<tr><th></th><th># Monitoring</th><th>#Passed</th><th>#Failed</th><th>On the Spot Training Completed</th></tr>
<tr><td>Positioning</td><td>27 (19%)</td><td>27</td><td>0</td><td>NA</td></tr>
<tr><td>Mealtime</td><td>55 (40%)</td><td>52</td><td>3</td><td>Yes</td></tr>
<tr><td>Snacks</td><td>5 (4%)</td><td>5</td><td>0</td><td>NA</td></tr>
<tr><td>Med</td><td>38 (27%)</td><td>35</td><td>3</td><td>Yes</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Administration					
Oral hygiene	14 (10%)	14	0	NA	

Out of 139 monitorings completed for this period, only six were failed. This percentage failed contradicted the guidelines on the monitoring form which stated that if question #3 was missed then the monitor should be marked as failed. Please see below for details:

Below is the highest to lowest number of specific questions missed based on all monitoring scoring less than 100%.

- Question #3 – Plan is being performed as written: Missed 11 times
- Question #1 – PNMP/DP/Instructions is present and or easily: Missed 5 times
- Question #2 – Materials/equipment are present, working or utilized: Missed 5 times
- Question #8 – Staff has been or reports being trained on individual program: Missed 3 times
- Question #5 – Staff explains plan rationale, goal(s), desired outcome (s): Missed 2 times
- Questions #4- Staff communicates with individual before and during activities: Missed 1 time
- Question #6–Staff explains risks associated with NOT implementing the program: Missed 1 time
- Question #7- Staff identifies individual triggers(from DP/PNMP): Missed 1 time
- Question #10- Staff identifies who to contact if there is a problem: Missed 1 time

Based on review of monitoring completed between 1/1/13 to 10/5/13, the PNMP monitoring process did not cover all areas that were likely to provoke swallowing difficulties or increase PNM risk. 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.

In order to move towards substantial compliance, RGSC must ensure the data contained within the database is accurate and reflects true staff performance as it relates to plan implementation.

Monitoring for Individuals in Samples

For individuals in Sample O.1, PNM compliance monitoring over the past three months for ten of ten individuals (100%), 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

#	Provision	Assessment of Status	Compliance
		individuals' PNMT assessment and/or the individuals' plans/IHCPs. Frequency of monitoring primarily defaulted to the default monitoring schedule. There was not a clear schedule or guidelines that identified the frequency in which individuals at high, moderate and low risk would be monitored throughout the year. In order to move towards substantial compliance, RGSC should develop a clear monitoring schedule or guideline that outlines the monitoring schedule and how it is based on levels of risk.	
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 15 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 15 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. Zero of 15 individuals' records (0%) in Samples O.1 and O.2 included evidence that the team discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual. Trigger sheets were reviewed for the 10 Individuals in Sample O.1 and O.2 for the past three months. This totaled a review of 30 trigger sheets. Eight of 30 Trigger sheets (27%) were completed correctly. Twenty-nine of 30 Trigger sheets (97%) were reviewed at a minimum daily by the RN but not consistently every shift as directed. Zero of 30 Trigger sheets (0%) included individualized triggers as indicated. For example: Individual # 118'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:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The trigger sheet contained multiple gaps in data due to lack of completion. • Triggers when occurred were not consistently documented on the trigger sheet. • Case Manager's review of the trigger sheet was inconsistent. In order for the Facility to move towards substantial compliance: • The Facility must ensure the Aspiration Trigger sheets are personalized and only contain information specific to the person. All data taken should be meaningful and relevant to the plan of care. • The trigger sheets should be completed in a consistent manner and reviewed in a timely manner by the appropriate supervisor(s). • Thresholds for PNMT referral or for other actions related to PNM management should be integrated into the IHCP.	
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.	**Evaluation of Individuals who receive Enteral Nutrition** 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. Three of three individuals who received enteral nutrition (100%) were evaluated at a minimum annually as evidenced by review of their IRRF, ISP, Habilitation Assessment, APEN and Nutritional Assessment. Three of three 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. 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. **Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition** One of three individuals (33%) from Sample O.3 who received enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate.	Noncompliance

#	Provision	Assessment of Status	Compliance
		One individual (Individual #19) was identified as potentially benefitting from oral motor treatment. This individual was provided with a plan to return to oral intake but this was not provided to the Monitoring Team 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. • If plans were monitored as outline in the plan • If plans were modified as needed by the IDT Because the plan for returning to oral intake was not provided, the Monitoring Team was not able to determine if the plans included all of the following components: • Staff training required prior to implementation; • Staff roles and responsibilities (e.g., implementation, monitoring); • Time and schedule of interventions; • Specific triggers for when the plan should be stopped; • Milestones for progressing with the plan; • Documentation requirements (method for tracking progress); and • 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 was not provided at the time of the review. In order for the Facility to move towards substantial compliance, it must ensure all individuals are provided with oral motor evaluations in which strategies to improve oral musculature for the possible return to oral intake or to aide in the tolerance of secretions are clearly evaluated and explored. Treatment notes must clearly outline the plan of care and how success will be measured. The need for staff training and thresholds for progression will need to be included as part of the plan of care.	

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 11/6/13 2. RGSC Action Plan 11/5/13 3. RGSC Policy 500-02 PNMP Policy (rev 4-2013) 4. RGSC Policy 500-02 Occupational and Physical Therapy Services (rev: 8/2012) 5. Section P Presentation Book Record reviews: 6. Sample P.1: Individuals #19, #48, #51, #60,#72, #114, #118, #126, #134, and #140 7. Sample P.2: Individuals #4, #118, and #126 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. QA reports/matrix since the last compliance review 10. Habilitation Therapy Annual Assessment 11. Habilitation Therapy Update 12. Wheelchair/Adaptive Equipment Maintenance Log (last 6 months) 13. IRRF template 14. IHCP template

	15. List of new employees since last compliance visit and their PNM related performance check offs 16. PNM Monitoring Tool template 17. Last three months of PNM monitoring data (including date, activity monitored, time of monitor, person conducting monitor) 18. 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. HOBE assessments aa. PNMT assessments and any other PNMT documentation other than IPNs in the last 12 months, if not already submitted bb. OT/PT assessments in the last 12 months cc. Six months IPNs dd. Trigger sheets completed in the last 6 months, including the current one ee. PNMPs in the last 12 months, including pictures ff. Dining Plans in the last 12 months, including pictures gg. Completed PNM-related monitoring sheets in the last three months hh. Evidence of effectiveness monitoring completed within the last six months ii. Direct intervention plan and supporting documentation for implementation of the plan (e.g., monthly progress notes) jj. Individual notebooks (PNM section) **People Interviewed:** 1. Jane Augustine PT Director of Habilitation Services 2. Betty Perez Rehab Tech II **Meeting Attended/Observations:** 1. PNMT meeting 11/19/13 2. Morning Medical 11/20/13 3. Mealtimes and Transitions (La Paloma, El Paisano)
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 11/6/13, and Action Plan dated 11/5/13. 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 clear descriptions regarding how the compliance score was obtained. 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 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 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 being in compliance with P.1, P.3, and P.4. This was inconsistent with the Monitoring Team's findings of noncompliance with provisions P.1, P.2, P.3 and P.4. The Action 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, especially on El Paisano. A system still did not exist and 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, 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. Assessments did not clearly identify how areas in which skill acquisition or generalization of skills were needed were not consistently included as part of the

	assessment. **Provision P.2:** This provision was determined to be not in compliance. Therapy services were not consistently integrated into the ISP. There was justification as to why it was felt that the individuals would benefit from many of the OT/PT programs. Treatment notes did not contain a summary in which total progress and/or functional gains were defined. **Provision P.3:** This provision was determined to be not in compliance. The Facility was unable to provide information regarding if staff had been trained on individuals' plans of care. 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. Additionally, many procedures were undocumented and were in need of being formalized.

#	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 10 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 three individuals who received direct PT care. **Timeliness of Assessments** Four of four individuals admitted since the last review (100%) received an OT/PT screening or assessment within 30 days of admission or readmission. Four of four 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		surpassing compliance with this metric. Six of nine individuals' OT/PT assessments in sample P.1 (67%) 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 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 order to move towards substantial compliance, the Facility must ensure assessments are completed in a timely manner. Nine of nine assessments or updates in Sample P.1 (100%) were current within 12 months for individuals who are provided PNM supports and services. **OT/PT Assessment** Based on review of the sample of assessments, the comprehensiveness of the OT/PT assessments for samples P.1 were as follows: • Nine of nine individuals' OT/PT assessments (100%) were signed and dated by the clinician upon completion of the written report. • Nine of nine assessments (100%) included diagnoses and relevance to functional status. • Nine of nine 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 nine assessments (100%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous years or assessments. • Nine of nine individuals' OT/PT assessments (100%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. • Nine of nine assessments (100%) included medical history and relevance to functional status. • Nine of nine assessments (100%) addressed health status over the last year. • Nine of nine assessments (100%) listed medications and potential side effects relevant to functional status. • Nine of nine assessments (100%) included documentation of how the individual's risk levels impact their performance of functional skills. • Nine of nine assessments (100%) included evidence of observations by OTs and	

#	Provision	Assessment of Status	Compliance
		PTs in the individual's natural environments (day program, home, work). • Nine of nine assessments (100%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. • Nine of nine assessments (100%) included discussion of the expansion of the individual's current abilities. • Six of nine assessments (67%) included discussion of the individual's potential to develop new functional skills. • Zero of nine 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. • Nine of nine assessments (100%) 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. • Zero of nine assessments (0%) included a monitoring schedule. The monitoring schedule primarily listed was the default schedule that is based upon risk. While the monitoring portion of the assessments often stated that the default schedule would be utilized. There was no evidence in the form of a guideline or procedure that clearly identified the default schedule. • Nine of nine assessments (100%) included a re-assessment schedule. The reassessment schedule at RGSC was an updated every year if receiving direct or indirect services. • Nine of nine 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 nine assessments (100%) provided a statement regarding "Factors for Community Placement" that is detailed and lays out the supportive services needed for successful living. • Eight of nine (89%) 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. As reported in Provision L1, the PT/OT assessment indicated specific measurements when assessing spasticity in zero out of four examples (0%).	

#	Provision	Assessment of Status	Compliance
		In order for the Facility to move towards substantial compliance, the assessment must provide guidance as to how skills or treatment goals being worked on through direct treatment may be generalized and reinforced through the 24-hour day.	
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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. **OT/PT Interventions** For individuals receiving OT/PT supports and services, 10 of 10 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 zero of nine individuals in Sample P.1 (0%), the ISP/ISPAs addressed each of the recommendations outlined in the current OT/PT assessment. **Direct OT/PT Interventions** Three of three individuals' direct intervention plans (100%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. For three of three individuals' records (100%) reviewed, the current OT/PT assessment identified the need for direct intervention with rationale. For zero of three individuals' records (0%) whose therapies had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. Treatment notes did not include clear indicators and/or goals that had clearly been worked on and the overall summary in which total progress with goal along with functional gains were defined. **Indirect OT/PT Programs** The implementation of these plans is also discussed under Section O4 for PNMPs and in Section S for skill acquisition plans. **Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP** 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.	Noncompliance

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		Nine of nine ISPs or ISPAs in sample P.1 (100%) clearly showed review of the PNMP and discussion of needed revisions. In seven of nine of the ISPs or ISPAs reviewed (78%), skill acquisition programs or opportunities for skill acquisition that had been recommended in the OT/PT assessment were present. For zero of nine individuals from Sample P.1 (0%), the ISP/ISPAs contained measurable objectives related to functional individual outcomes. Measurable outcomes were not consistently included as part of the ISP or ISPA. As reported in Provision L1, of four individuals with a diagnosis cerebral palsy whose records were reviewed by the Monitoring Team, the ISP and/or IRRF documented all necessary supports and services for CP and spasticity in zero out of four examples (0%). Zero of three individuals receiving direct OT/PT Services (sample P.2) (0%) were provided with comprehensive progress notes (IPNs) that contained each of the indicators listed below. • 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). • 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. • Reported the consistency of implementation. • Identified recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress. • 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 nine individuals from Sample P.1 (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	

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		• Recommendations/revisions to the indirect intervention and/or program as 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.	**Monitoring System** 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;	Noncompliance

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		• 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 formally shared for appropriate follow-up by the relevant supervisor; • Require statement of discharge criteria; • Define a formal schedule for monitoring to occur. It should be noted that RGSC was in the process of revising their OT/PT policy but this had not been completed as of this date. This policy will be reviewed at subsequent visits. For nine of nine 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 log provided to the Monitoring Team only identified if the equipment was broken and repaired and did not include the repaired date. Therefore timeliness of repair could not be reviewed. For example, Individual #140's merry walker was broken on 5/15/13. In response to this issue, the log only stated that a new walker was ordered and received but did not include the date it was received. Failure to provide the repaired date resulted in an inability to determine if repairs were made in a timely manner.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-Assessment (11/6/2013) 2. RGSC Action Plan (11/5/2013) 3. Presentation Book, November 2013 4. RGSC Oral Suction Toothbrushing Procedure, ICF-IID 400 17, undated draft 5. RGSC DRAFT Standard Operating Procedure ICF-IID Suction Toothbrushing, revised August 2013 6. Standard Operating Procedure ICF-IID 400 16: Pre-Medication for Medical and Dental Procedures, revised October 2013 7. List of dental providers 8. List of all pending and completed restorative treatments that were provided during the review period 9. Alpha list of all individuals who had, and did not have, completed dental radiographs during the past 12 months 10. Copy of the dental schedule for the past six months 11. List of all missed dental appointments for past six months 12. Copy of all data, and trends analysis, for all individuals who were provided a dental rehearsal during the past six months 13. Nursing IPNs, and dental note for Individual #12 14. List of missed dental appointments **People Interviewed:** 1. Mario Menchaca, Dental Hygienist 2. Lorraine Hinrichs, ICF-IID Program Director **Meetings Attended/Observations:** 1. None
	Facility Self-Assessment: The Facility's self-assessment indicated that the Facility was not in substantial compliance with Sections Q.1 and Q.2. The Monitoring Team concurs with this assessment. The Monitoring Team has concern over the Facility's self assessment process for Provision Q, as in many cases, data was contradictory to the Monitoring Team's findings, there were discrepancies with what was reported as part of the document request, and the self-assessment did not assess efficacy of clinical programs. The following are some examples of concerns regarding the self assessment process for Sections Q.1 and Q.2: • The self-assessment indicated that the Facility had a dental emergency on 8/2/13; however, during the Monitoring Team's meeting with the ICF director and dental hygienist, the Monitoring Team was informed that no dental emergencies occurred during the monitoring period, and no documents were provided for the dental emergency. • The self-assessment indicated that 5 out of 5 (100%) extractions were completed, but there was no assessment as to the timeliness of the extraction. The Facility should assess if clinical services were offered within a clinically acceptable period of time.

	• The self-assessment indicated that three individuals currently used suction toothbrushes, but there was no assessment of efficacy of the use of suction toothbrushing. • The self-assessment indicated that review of data indicates 110 out of 120 (88%) direct support professionals are current with their oral care training, and the remaining 10 are scheduled for training on 9/23/2013. During the on-site meeting with the ICF Program Director and dental hygienist, the Monitoring Team was informed that nurses had not yet been trained on oral hygiene, or suction toothbrushing, but will be trained in the future. The assessment did not comment on the need to train nursing staff. • The self-assessment determined that 9 out of 64 were not current with dental radiograms; however, the Monitoring Team was informed by the dental hygienist and provided documentation that 58 out of 60 individuals were current with dental radiograms. The self-assessment and documents provided for review relied on significantly different population size. On the day the compliance visit began, there were 65 individuals in residence. • The self-assessment indicated that the Facility's dental policies were "accurate and current"; however, the Monitoring Team determined that the Facility's policies did not have all necessary components necessary for operation needs. For example, the Facility's policy for suction toothbrushing indicated that the hygienist would assess the administration of suction toothbrushing by one nurse each week, and at the time of this review, the Monitoring Team was informed by the hygienist that this activity was not being completed regularly. Furthermore, the suction toothbrush policy did not effectively delineate how all individuals would be regularly assessed for the potential need of suction toothbrushing. The Facility should have a standardized process to regularly assess individuals for the administration of suction toothbrushing. The Procedure for premedication for medical and dental procedures appeared to be comprehensive. The Monitoring Team recommends that the Facility review its self assessment process for Section Q, and ensure that the self assessment assesses the efficacy of its programs, as well if all compliance issues are in place.
	Summary of Monitor's Assessment: The Monitoring Team concurs with the Facility's self-assessment of noncompliance for Section Q. The Monitoring Team recognized that the Facility maintains clinically adequate community resources to provide dental services, and ensures that individuals are provided timely restorative dental care, and regular dental imaging. The Facility must, however, continue to improve dental services by enhancing its programs for oral hygiene at the living area, the use of suction toothbrushing, monitoring individuals following dental anesthesia, developing a dental scheduling system that enables efficient and effective review of dental services provided to each individuals, and implementing a dental QA program that assesses the efficacy of dental services and potential adverse outcome following dental services. The following are some additional comments, specific for each Section of this Provision: Section Q.1: The Facility demonstrated effective follow-up on restorative dental needs and dental radiography. The Facility reported one dental emergency during the reporting period, and the Monitoring Team determined that the Facility did not provide prompt or effective treatment for the dental

	emergencies. The Monitoring Team recommends that the Facility enhance its procedure for managing dental emergencies, and ensure that dental emergencies are triaged promptly. For the most part, annual dental appointments were completed, and new appointments had been established to complete those that were delayed. The Facility did not have functional processes in place to address the Facility's oral hygiene and suction toothbrushing programs. The Monitoring Team concurs with the Facility's self assessment of noncompliance, and recommends that the Facility enhance training, supervision, and trends analysis for the provision of oral hygiene at the living area, including suction toothbrushing. Also, the Facility should ensure the development of procedures that delineate the Facility practices related to the provision of dental and oral hygiene care. Section Q.2: The Monitoring Team concurs with the Facility's self assessment of noncompliance with Section Q.2, and strongly recommends that the Facility develop a program that helps individuals become accustomed to the dental milieu, and associated oral treatments; and should ensure that the program is offered at a frequency that will help the individual overcome challenges related to the dental office experience. Also, the Facility must track and trend the effectiveness of the program for each individual. The Facility must enhance its process for scheduling and tracking of dental services, so that the Facility can ensure all individuals have the needed dental appointments and services. The Facility must develop a clinically effective mechanism to ensure close monitoring of all individuals following TIVA and other forms of anesthesia, including pre-treatment oral sedation. It is essential that the Facility develop a dental QA process that assesses the quality and efficacy of dental services, including regularly assessing potential adverse outcomes, such as pneumonia, behavioral exacerbation, and injuries, such as fractures, following dental procedures.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	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. <u>Dental Administration</u> To assess Dental administration, the Monitoring Team discussed dental administration with Mario Menchaca 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 were responsible to maintain the dental appointment and follow-up schedule.	Noncompliance

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		Restorative dental care: To assess effectiveness of the Facility's provision of restorative dental care, the Monitoring Team reviewed the following documents: • List of all pending restorative treatments • Date when the underlying condition requiring the restorative treatment was first identified • Date when the restorative treatment was completed, or date of pending treatment • Documentation why restorative treatment has not been completed • Copy of the most ISP or related document, indicating the IDT's awareness of the need for restorative treatment The Facility reported that during the reporting period, 13 individuals were identified as requiring restorative dental care, and 10 out of 13 (77%) had completed restorative treatment within 30 days of initial diagnosis. For the three individuals who had not completed their restorative dental care: • Individual #140: Was identified on 10/21/2013 as requiring a composite filling, and treatment is scheduled for 12/2/2013. The Monitoring Team recognizes that this is an acceptable time frame for treatment. • Individuals #123, and #65 are both pending restorative treatment secondary to challenging behaviors. Summary: In general, the Facility ensures timely, and clinically appropriate restorative dental treatment. Dental Radiography To assess if the Facility provides dental imaging, at the level of generally acceptable standard of care, the Monitoring Team requested the following documentation: • Alpha list of all individuals who the Facility has identified as not being current with dental radiography • Alpha list of all individuals who have not had bitewing dental x-rays (or alternative to bitewings) within the past 24 months • Policy and/or procedure specific to dental radiography • For the first five and last five individuals on the list of individuals not having had bitewing radiographs within the past 24 months: o Reason why dental x-rays are not current o Copy of IDT minutes and/or ISP minutes that comment on delinquent dental x-rays, and specific plan to address incomplete dental x-rays	

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		Documentation provided, and the findings from that documentation, was as follows: • The Monitoring Team was provided a document with the dates of the last set of bitewing radiographs for the first five and last five individuals listed on the current name key. The Monitoring Team noted that for all ten individuals, bitewing radiographs were obtained within the past 12 months for ten out of ten examples (100%). • The Facility provided documentation indicating that 58 out of 60 (97%) individuals were current with their required dental radiography. • The Facility did not have a current policy or procedure for dental radiography. Summary: The Monitoring Team compliments the Facility for ensuring that dental radiography is provided timely. The Monitoring Team recommends that the Facility develop a procedure that delineates its practice for obtaining dental radiography. <u>Dental Emergencies</u> To assess the Facility's process for managing dental emergencies, the Monitoring Team requested the following information: • Copy of all policies/procedures specific for "dental emergencies" • Alpha list for all dental emergency during past six months, and include: o Name o Description of dental emergency o Date, and time dental emergency was first identified • For the first five individuals on the list of dental emergency visits: o Progress notes documenting initial triage of the dental emergency (medical/or dental note) o Dental progress notes/dental records from initial evaluation through full resolution of treatment for the dental emergency (all associated note/records specific for initial and follow-up treatment for dental emergencies) o All documentation of IDT review/s, and recommendations, specific for the dental emergency The dental hygienist informed the Monitoring Team that there were no dental emergencies that occurred during the reporting period; however, the Facility provided a copy of a dental report, and two nursing IPNs for a reported dental emergency. <u>Policy review</u> The Facility revised its dental procedure for dental emergency; Standard Operating	

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		Procedure ICF-IID 400-12, Dental Services, dated 12/1/2012, revised October 2013. The only statement specific to emergency dental treatment was "Emergency room will be available for emergency dental evaluations and recommendations for the emergency room physician will be provided to the Dentist on Contract for further interventions within one business day". The Monitoring Team strongly recommends that the Facility develop and implement a dental procedure that clearly delineates the necessary steps for enabling emergency dental care. <u>Management of dental emergencies</u> The Facility provided documentation for one individual who experienced a dental emergency during the reporting period. Individual #12: A nursing IPN dated 8/2/2013 documented that the Individual demonstrated pain, and swelling of the left cheek, and the Individual was triaged to the local emergency department. A follow-up nursing IPN documented that the Individual was triaged at the local emergency department; however, because of maladaptive behaviors the Individual was not examined by the emergency room physician, and no labs or x-rays were obtained. The Individual was started was started on antibiotics and Motrin for pain. The Facility medical provider did not examine the individual, and it was not until 8/13/2013 when the Individual eventually was evaluated by a dentist. The dentist indicated that the Individual was experiencing severe inflammation, but was unable to perform an examination or provide treatment, and recommended that the Individual undergo sedation for treatment. The Facility did not provide follow-up dental records to indicate that this issue had resolved. Summary. The Facility reported one dental emergency during the reporting period, and the Monitoring Team determined that the Facility did not provide prompt or effective treatment for the dental emergencies. The Monitoring Team recommends that the Facility enhance its procedure for managing dental emergencies, and ensure that dental emergencies are triaged promptly. <u>Suction Toothbrushing</u> To assess the Facility's process for providing suction toothbrushing, the Facility requested the following documentation: • Alpha list of all individuals who are provided suction toothbrushing • Alpha list of all individuals identified as needing suction toothbrushing, but not currently receiving suction toothbrushing. • For the first two and last three individuals on the list of those who are provided suction toothbrushing (Individuals #), please provide:	

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		o Copy of the most recent assessment results used to evaluate efficacy of suction toothbrushing for the individual o Copy of most recent oral health rating scale o Copy of the most recent ISP, and/or IDT minutes specific to the use of suction toothbrushing o Documentation assessing the efficacy of the use of suction toothbrush The Facility's policy for suction toothbrushing indicated that the hygienist would assess the administration of suction toothbrushing by one nurse each week, and at the time of this review, the Monitoring Team was informed by the hygienist that this activity was not being completed regularly. Furthermore, the suction toothbrush policy did not effectively delineate how all individuals would be regularly assessed for the potential need of suction toothbrushing. The Facility should have a standardized process to regularly assess individuals for the administration of suction toothbrushing. The Facility provided a draft copy of an oral suction toothbrushing procedure, ICF-IID 400 17, undated. The procedure is specific for individuals with who are prescribed percutaneous endoscopic gastronomy tubes, and individuals identified as having a need for suction toothbrushing by the IDT. The procedure, however, did not address the process for periodic screening of Individuals for the possible need for oral suction toothbrushing. For example, individuals with recurrent pneumonia should be assessed for the need of suction toothbrushing. The Facility provided a document indicating that three Individuals were provided suction toothbrushing on a regular basis, and indicated that no additional individuals required suction toothbrushing. The Facility did not provide copies of the assessment tool used to determine the need for suction toothbrushing. The dental hygienist informed the Monitoring Team that the Facility has yet to complete a formal screening tool to assess the need for suction toothbrushing; has not yet trained all relevant staff on suction toothbrushing; and does not have a specific policy or procedure that delineates the Facility's actions for the provision of suction toothbrushing. Specific documentation requested was not provided for review. Summary: The Facility must develop all necessary process to enable initial and period assessment for the need for suction toothbrushing; specific staff training venues to ensure that all relevant staff are initially and periodically trained on the use of suction toothbrushing; and ensure periodic assessment of staff administering suction toothbrushing. <u>Oral Health Care at the Living Area</u>	

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		To assess the Facility's mechanism to ensure that oral health care needs were provided at the living area, the Monitoring Team requested the following documentation: • Oral health care plans for the first and then every fifth individual listed on the current name key, for a total of ten examples. • Evidence that oral health care treatments were routinely assessed at the living area, such as oral hygiene spot checks • Current ISP documenting oral healthcare needs The dental hygienist informed the Monitoring Team that the Facility does not have a formal process to routinely assess and trend the provision of oral hygiene of oral health care, and commented that the Facility will develop a formal process to collect trends data, specific to oral health care. The Facility did not provide copies of ISPs, or addendums to the ISPs, documenting the condition of the individuals' oral health care status; prognosis of oral health care issues, and how oral health care issues may impact the Individuals life; or all necessary supports and services required to help ensure appropriate oral health care. The Facility did provide copies of physical/nutritional management plans for ten individuals. Each plan was cursory, and provided very limited information whether the Individual would provide self oral hygiene, or if assistance was needed. The frequency, and specific supplies necessary, for the individuals' oral health was not indicated. Summary: The Facility must enhance its monitoring of oral healthcare at the living area, by ensuring regular documentation of the provision of oral health care, and ensure that staff are routinely assessed on their ability to provide oral hygiene. <u>Annual Dental Examinations and Routine Dental Hygiene</u> To assess the provision of routine dental services, the Monitoring Team requested the following information: • Copy of last six months and next six months appointment schedule for annual dental examinations • As of the day prior to the compliance visit, alpha list of all individuals who were <u>not</u> current with their annual dental examination by the dentist, and also a list of all individuals who had not fully completed their annual dental examination. Please include the following information: o Name o Date of previous years annual dental examination o Scheduled date for most recent dental examination	

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		The Monitoring Team was provided with a list of individuals who were not current with their annual dental examination by the dentist. A total of 12 individuals, out of the current census of the Facility of 65 individuals, had not completed their annual dental examination (18%). The Facility provided documentation stating that seven out of the 12 cases were rescheduled by the Facility, and five out of 12 were rescheduled by the dental office because the dentist was out of town. There was no reason provided for the Facility's rescheduling of appointments. The Facility provided a list of dates indicating when the individuals will be provided their annual dental examination. All 12 individuals are scheduled to follow-up with the dentist for their annual dental examination by the first week of December 2013. The Facility did not provide IPNs or IDT meeting minutes documenting the reason for the delay with the annual dental examinations. Summary. It was apparent to the Monitoring Team that 82% of individuals served by the Facility received their annual dental examination within 360 days from the previous annual dental examination. For individuals who had not received a timely annual dental examination, the Facility had already scheduled all 12 cases to be evaluated by the dentist by December 2013. Conclusion: The Facility demonstrated effective follow-up on restorative dental needs, and dental radiography. Provision of emergency dental care needs improvement, and procedures must be clarified. For the most part, annual dental appointments were completed, and new appointments had been established to complete those that were delayed. The Facility did not have functional processes in place to address the Facility's oral hygiene and suction toothbrushing programs. The Monitoring Team concurs with the Facility's self assessment of non-compliance, and recommends that the Facility enhance training, supervision, and trends analysis for the provision of oral hygiene at the living area, including suction toothbrushing. Also, the Facility should ensure the development of procedures that delineate the Facility practices related to the provision of dental and oral hygiene care.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop	To assess compliance issues for Provision Q.2, the Monitoring Team reviewed the Facility's processes related to dental Quality Assurance, issues related to dental TIVA and dental scheduling, and programs to reduce the need for dental sedation.	Noncompliance

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	and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	<u>Dental Schedule:</u> To assess the Facility's ability to maintain an efficient and effective dental scheduling system, and to determine if all dental services are current, the Monitoring Team requested the following documentation: • Copy of dental schedule for past six months, and pending six month period o List of all "missed" appointments and ▪ Reason for missed appointment ▪ Date appointment was missed ▪ Date follow-up appointment was scheduled ▪ Specific effort document to help mitigate future missed appointments. • Total number of missed dental appointments during that past six months • Number of missed appointment during the reporting period • Total number missed • Total number scheduled • Number of missed appointments because of illness of the individual • Number of missed appointments because of staffing issues at the living area • Number of missed appointments because of staffing issues at the dental office • Number of missed appointments because living area forgot to transport the individual to the dental clinic • Number of missed appointments because of a TIVA related issue (e.g., not enough TIVA days; another individual required that particular TIVA appointment for a dental urgency, etc) • Number of missed appointments because appropriate consent was not obtained • Number of missed appointments because of other, non-specified issues • Committee Meeting minutes, associated data, and data analysis used by the facility to improve compliance with dental services The Facility provided a list indicating missed appointments, and the reason for missed appointments that occurred during the reporting period: • The Facility documented that a total of 160 dental appointments were scheduled for dental appointments, during the reporting period, with 42 missed appointments; hence 118 out of 160 appointments (74%) occurred as scheduled. • Zero out of 160 scheduled appointments (0%) were missed secondary to staffing issues at the living area. • Zero out of 160 (0%) missed appointments were secondary to transportation related issues. • 17 out of 160 (17%) missed appointments were due to dental clinic issues, such as staffing issues at the dental clinic.	

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		• Two out of 160 (0.12%) missed appointments were due to not obtaining consent for treatment. • 23 out of 160 (14%) missed appointments were due to other reasons. The dental hygienist informed the Monitoring Team that the Facility has still not implemented the DADS dental database system to schedule and track dental appointments and services, and continues to use a spreadsheet for scheduling purposes. The Monitoring Team reviewed the spreadsheet and it did not enable efficient, or effective review with regard to tracking of specific types of dental services that were provided and pending. For example, the Monitoring Team was unable to readily determine if all annual dental examinations and hygiene were completed as scheduled. Summary. The Facility should develop a scheduling system that enables efficacious tracking of all dental services. <u>Total Intravenous Anesthesia (TIVA)</u> To determine the Facility's availability of providing adequate quantity of TIVA services for dental procedures, and to assess the Facility's process for ensuring safe administration of TIVA, the Monitoring Team requested the following information: • Number of TIVA hours per month available at the Facility • Number of individuals who have been provided TIVA services each month, for the past six months, beginning with 4/1/2013 • Alpha list of all individuals who require TIVA for dental services • Alpha list of all individuals who were provided TIVA for dental services during the past 12 months • For the first five and last five individuals who were provided TIVA anesthesia were requested: o Copy of TIVA records associated with the most recent use of TIVA anesthesia o Copy of all nursing notes associated with post anesthesia monitoring of the individual, following general anesthesia, once back at the living area (or infirmary) • List all individuals who were provided TIVA anesthesia during the past six months, and who were diagnosed/treated/and or hospitalized for pneumonia (any type of pneumonia). o Date that general anesthesia was provided o Date pneumonia was diagnosed/treated/or person hospitalized • Statement by the Facility's dental director indicating that all individuals who require TIVA for their oral health care needs, are afforded TIVA services for their	

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		annual dental assessments for a minimum of two dental hygiene opportunities per year, and more if clinically indicated; and for all necessary restorative treatments, without a delay in treatment of more then 14 business days. The Facility provided a document stating that "the Facility does not provide TIVA for our individuals; therefore, this request does not apply". No other documentation was provided for this document request. Summary: Although the Facility does not provide onsite TIVA, the Facility does refer Individuals off-site for general anesthesia; therefore, the Facility should track data of individuals who require TIVA or general anesthesia for their dental services, and have a process to monitor individuals before and after returning from dental services using anesthesia. <u>Pre-treatment oral sedation</u> The Facility provided a operating procedure entitled Standard Operating Procedure, ICF-IID 400 16; Premedication for Medical and Dental Procedures, dated October 2013. The procedure outlines the Facility's inclusion of providing pre-treatment oral sedatives for dental and medical procedures. The Facility provided a list of individuals who require pre-treatment oral sedation for dental services on a regular basis. The list indicated that 12 individuals require pre-treatment oral sedation for oral healthcare treatment. The Facility provided a document indicating that the Facility did not collect or analyze data, or provide a systems review for the Facility's usage of pre-treatment oral sedation. The Monitoring Team requested evidence, such as nursing and medical provider's IPNs, and monitoring forms, and assessments, to support the clinical monitoring of Individuals prior to, during and following the administration of a pre-treatment oral sedation. The Facility indicated that no such documents were available. Summary: The Facility should have a process in place that enables the safe administration, and monitoring of pre-treatment oral sedation for dental services, when clinically indicated. <u>Dental quality assurance:</u> To assess the Facility's process to monitor the quality of dental services, and develop strategies to enhance oral health care at the Facility, the Monitoring Team requested the following documents:	

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		• List of all dental QA indicators • All data, trends analysis, summaries, committee minutes, action plans, and follow-up to action plans for the Facility's dental QA process, for this reporting period The Facility's ICF director, and the dental hygienist informed the Monitoring Team that it had yet to implement a dental QA process that assesses effectiveness of dental services and potential adverse outcome secondary to dental services. The requested documents were not provided by the Facility. Summary: The Facility should consider developing a dental quality assurance process to assess the quality and efficacy of dental services, and to regularly assess potential adverse outcomes, such as pneumonia, behavioral exacerbation, and injuries, such as fractures, following dental procedures. <u>Programs to Help Reduce the Need for Sedation</u> 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 October 2013. 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. The Facility's ICF Program Director and the dental hygienist 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, and that individuals were provided a dental rehearsal at least monthly. Further discussion indicated that the program specifically focuses on the Individuals becoming used to a specific dental hygienist, who would be responsible to assist the individual at each dental visit. Following a discussion with the Monitoring Team, the ICF Program Director and dental hygienist both concurred that the program was too dependent on a single staff member, and individuals should be provided more frequent program occurrences. Review of the first five of ten data tracking sheets for dental rehearsals indicated that the frequency of program implementation was extremely low: • Individual #66 was provided four dental rehearsals during the past six months • Individual #91 was provided one dental rehearsals during the past six months • Individual #36 was provided three dental rehearsals during the past six months • Individual #48 was provided 3 dental rehearsals during the past six months	

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		• Individual #51 was provided one dental rehearsal during the past six months Summary: The Facility has yet to develop and implement a clinically effective mechanism to help minimize the use of sedation for dental treatments. The Facility must develop a program that helps individuals become accustomed to the dental milieu and oral treatments, and ensure that the program is offered at a frequency that will help the individual overcome challenges related to the dental office experience. Also, the Facility must track and trend the effectiveness of the program for each individual. Conclusion: The Monitoring Team concurs with the Facility's self assessment of noncompliance with Section Q.2, and strongly recommends that the Facility develop a program that helps individuals become accustomed to the dental milieu and associated oral treatments; and ensure that the program is offered at a frequency that will help the individual overcome challenges related to the dental office experience. Also, the Facility must track and trend the effectiveness of the program for each individual. The Facility must enhance its process for scheduling and tracking of dental services, so that the Facility can ensure all individuals have the needed dental appointments and services. The Facility must also develop a clinically effective mechanism to ensure close monitoring of all individuals following TIVA and other forms of anesthesia, including pre-treatment oral sedation. It is essential that the Facility develop a dental QA process that assess the quality and efficacy of dental services, and to regularly assess potential adverse outcomes, such as pneumonia, behavioral exacerbation, and injuries, such as fractures, following dental procedures.	

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:	Documents Reviewed: 1. RGSC Self-Assessment, dated 11/6/2013 2. RGSC Action Plan 11/5/2013 3. RGSC Policy- 500-03 Communication Services (rev October 2013) 4. Facility Section R Presentation Book Record Reviews of Individuals: 1. Sample R.1: Individuals #8, #45, #48, #60, and #131 2. Sample R.2: Individuals #81, #115, and #149 3. Sample R.3: Individuals #8, and #48 4. Sample R.4: Individuals #19, #77, #97, #98, and #118, 5. List of current SLPs, caseloads and ratios 6. Copies of each SLP's current license and ASHA certification 7. Continuing education and training completed by the SLPs in the past 12 months 8. Facility list of new admissions since the last review 9. Tracking log of SLP assessments completed since the last review 10. Facility list of individuals with severe language deficits 11. Facility list of individuals with PBSPs and replacement behaviors related to communication 12. PBSP minutes and attendance rosters for the past six months 13. Facility list of individuals with Alternative and Augmentative communication (AAC) devices 14. Facility AAC screening forms 15. Facility AAC-related database reports/spreadsheets 16. Facility list of general common area AAC devices 17. Facility list of individuals receiving direct communication-related intervention plans 18. Competency Based Training Forms for staff in sample **People Interviewed:** 1. Belinda Lopez MA/CCC-SLP 2. Sotera Villalpando MA/CCC-SLP 3. Six 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 11/6/13 and Action Plan dated 11/5/13 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 compliance with Provision R.1 and noncompliant with Provisions R.2 to R.4. This was consistent with the Monitoring Team's findings of compliance with Provision R.1 and

	noncompliance with Provisions 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. For example, RGSC included assessment indicators under R.1 when the focus of R.1 is more towards staffing. 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: RGSC requested reduced monitoring for sections R.2, R.3., and R.4. As part of this request, RGSC chose the individuals to be included as part of the sample. The individuals chosen were those that had received newer assessments, treatment plans, etc. Since the review was limited in sample and scope, substantial compliance could not be rated by the Monitoring Team for Sections R.2 through R.4. Provision R.1 was found to be in substantial compliance. The speech department was fully staffed and had had the time needed to develop more guidelines and process that would assist them in being able to manage their caseload as well as other responsibilities. The increase in communication skill programs was felt to be reflective of their increased ability to perform the tasks needed. **Provision R.1:** This provision was determined to in substantial compliance. RGSC did have a

	comprehensive communication procedure/policy that addressed all components of a functioning system. Additionally, staff reported that time has allowed them the opportunity to implement many processes that now allows for them to meet the needs of the individuals and for the caseloads to be appropriate at this time. **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 5 Individuals chosen by the Facility with severe expressive or receptive language disorders with assessments completed in the last 12 months. Sample R.2: Consisted of four individuals chosen by the Facility who received direct speech services. Sample R.3: Consisted of two Individuals chosen by the Facility with a PBSP and communication deficits. Sample R.4: Consisted of five Individuals with AAC systems. This provision was found to be in substantial compliance. While staffing has remained the same since the previous review, evidence has shown and staff have expressed that organization of procedures and time to complete paperwork and assessments due to current staffing ratios has occurred. This organization and ability to catch up with paperwork was noted through the development of the communication policy as well as a noted improvement in the timeliness of assessments. **<u>Staffing</u>** The Facility divided the Speech caseload alphabetically. As of this review, RGSC had two full time SLPs. The current staffing allowed for a caseload of approximately 32	Substantial Compliance

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		individuals, which appeared to be reasonable to conduct the daily activities and responsibilities of the SLP. However, many issues were noted that would not reflect adequate staffing. These include late entries and assessments not being completed in a timely manner. **Qualifications:** 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. **Continuing Education:** Based on a review of continuing education completed in the last 12 months, two of two 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 MBSI mP and Dysphagia Practice: Targeted Intervention through Standardized Physiologic Swallow Assessment **Facility Policy** RGSC had revised their communication services policy since the last compliance review. A local policy/process did exist that provided clear operationalized guidelines regarding the delivery of communication supports and services and outlined minimum components of communication supports and services.	

Speech Therapist	Course Title	CEU Hours
Belinda Lopez	Medication Administration for Nurses, Hab Conference	6
	Issues in Evaluation and Treatment of Individuals with developmental disabilities	9.5
	The MBSI mP and Dysphagia Practice: Targeted Intervention Through Standardized Physiologic Swallow Assessment	10
Sotera Villalpando	Issues in Evaluation and Treatment of Individuals with developmental disabilities	9.5
	Medication Administration for Nurses, Hab Conference	6
	The MBSI mP and Dysphagia Practice: Targeted Intervention Through Standardized Physiologic Swallow Assessment	10

#	Provision	Assessment of Status	Compliance
		RGSC provided a policy titled "Communication Services" that was last revised in October 2013. 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 • 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 • 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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. **Assessment Plan:** 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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>** Five of five 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 three years for all individuals. Four of four admitted individuals (100%) since the last review received a communication screening or assessment within 30 days of admission or readmission. For nine of 13 individuals in Samples R.1, R.2, R.3, and R.4) (69%), 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. Thirteen of 13 individuals in Samples R.1, R.2, R.3, and R.4 (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), the comprehensiveness of the communication assessments were as follows: • The Monitoring Team was unable to determine if speech and language (SL) assessments of the drawn sample were signed and dated by the clinician upon completion of the written report as the Facility did not provide copies of the original documents. It should be noted that based upon review of the last four assessments completed by one of the SLPs and provided as part of the initial document request, there was evidence that four of four of those assessments were signed and dated. • Two of five individuals' SL assessments (40%) were dated as completed at least 10 working days prior to the annual ISP; • Five of five individuals' SL assessments (100%) included diagnoses and relevance of impact on communication; • Five of five individuals' SL assessments (100%) included individual preferences, strengths, and needs;	

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		• Five of five individuals' SL assessments (100%) included medical history and relevance to communication; • Five of five individuals' SL assessments (100%) listed medications and discussed side effects relevant to communication; • Five of five individuals' SL assessments (100%) provided documentation of how the individual's communication abilities impacted his/her risk levels; • Four of five individuals' SL assessments (80%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day. • Five of five individuals' SL assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); • Five of five individuals' SL assessments (100%) 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; • Five of five individuals' SL assessments (100%) included discussion of the expansion of the individuals' current abilities. • Three of five individuals' SL assessments (60%) provided a discussion of the individuals' potential to develop new communication skills; For example, Individual #131 had difficulty maintaining appropriate volume during communication but there was no strategy or SAP to address the issue. • Five of five individuals' SL assessments (100%) 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. • Five of five individuals' SL assessments (100%) offered a comparative analysis of health and functional status from the previous year • Five of five individuals' SL assessments (100%) gave a comparative analysis of current communication function with previous assessments • Three of five individuals' SL assessments (60%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. Individual #48 was noted to have decreased receptive and expressive language but did not have a SAP to address difficulties. • Five of five individuals' SL assessment (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; • Five of five individuals' SL assessments (100%) had a reassessment schedule; • Five of five individuals' SL assessments (100%) supplied a monitoring schedule. • Five of five individuals' SL assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC	

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		devices/systems, as indicated for individuals with identified communication deficits. • Five of five individuals' SL assessments (100%) made a recommendation about the appropriateness for community transition. • Zero of five 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. Overall, the speech assessment continued to show improvement but still needed to do a better job in addressing identified communication difficulties as well as providing better guidance into how strategies and recommendations should be integrated into the daily schedule. It should be noted that the sample was chosen by RGSC and therefore cannot be used to substantiate compliance. During the next review, a random sample will be drawn and compliance will be measured. **SLP and Psychology Collaboration:** Based on review of two individuals' records chosen by the Facility (Sample R.3) with Positive Behavior Support Plans (PBSPs) the following was noted: • Two of two 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. • For two of two individuals (100%) communication strategies identified in the assessment were included in the PBSP. • For two of two individuals (100%) communication strategies identified in the assessment were included in the ISP. Based on review of the Positive Behavior Support Committee meeting attendance sheets since last compliance review, participation by a SLP was noted in zero of the 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 collaboration did appear to be improving as evidenced by the increased integration and collaboration of the plans of care.	
R3	Commencing within six months of	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a	Noncompliance

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	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.	smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. **Integration of Communication in the ISP** Based on review of the ISPs for individuals in Sample R.1 the following was noted: • In five of five ISPs reviewed (100%) 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. • Five of five ISPs reviewed (100%) 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. • Communication Dictionaries for five of five individuals (100%) were reviewed at least annually by the IDT as evidenced in the ISP and ISPAs. During the meetings, the IDT (including the DCP) discussed and revised the individual's communication dictionary as indicated. This offered an excellent example of integrated planning and discussion. • Zero of five ISPs reviewed (0%) included how communication interventions were to be integrated into the individual's daily routine. • Three of five ISPs reviewed (60%) 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 five ISPs reviewed (0%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. **Development And Implementation Of Functional Individual-Specific Assistive Communication Systems** No revisions were recommended for the communication dictionaries; therefore whether modifications were made in a timely manner could not 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: • One of four observations (25%) 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.	

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		• For four of four individuals (100%), staff instructions/skill acquisition plans related to the AAC system were available. **General Use AAC Devices:** RGSC had 49 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. • In zero of three areas and other environments (0%), all general use AAC devices were operational. • Thirty of the 49 general use AAC devices (61%) noted contained clear directives on how staff should use these devices. Directions were vague or missing and did not provide detailed instructions/directions to ensure consistent staff implementation for the other 19 of 49 (39%). • Forty-nine of 49 general use AAC devices (100%) noted had a clear function within that setting/situation. • Zero of three observations (0%) noted general use AAC devices 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. **Direct Communication Interventions** Review of the individuals' records from Sample R.2 showed the following: • Three of 3 individual's direct intervention plans (100%) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. • For two of three individuals' records (67%) reviewed, the current SLP assessment identified the need for direct intervention with rationale. While the SLP evaluations identified the need for supports there was no clear justification as to why the determined plan was functional or important of the individual. • For three of three individuals' records (100%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. • For two of three individuals (67%), information was present regarding whether the individual showed progress with the stated goal. • For zero of three individuals (0%), a description was found of the benefit of the device and/or goal to the individual. There was no evidence that the therapist	

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		reported on a monthly basis how the goal would support communication for the individual in their daily activities. • For two of three individuals (67%), a report was found regarding the consistency of implementation. • For two of three individuals (67%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. • For two of three individuals (67%) progress notes contained the consistency of implementation. • For one of three individuals (67%) progress notes occurred at a minimum monthly. Individual #81 and #149's progress notes were all late entries and at times extended back over 30 days. **Indirect Communication Supports:** Programs for individuals in Sample R.1 who received indirect communication supports were reviewed. • Five of five (100%) individuals' indirect plans (e.g., PNMPs, Dictionaries, SAPs) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. • For three of five individuals' SLP assessments (60%) reviewed, the current SLP assessment identified the need for indirect intervention with rationale. For zero out of five 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 three individuals (0%) receiving indirect Speech Services (Sample R.1) were provided with comprehensive progress notes that contained each of the indicators listed below. • Quarterly documentation for zero of three individuals (0%) 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 three individuals (0%) identified the benefit of device and/or goal(s). • Quarterly documentation for zero of three individuals (0%) identified consistency of implementation. • Quarterly documentation for zero of three individuals (0%) identified recommendations/revisions to the program as indicated and related to the	

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		individual's progress or lack of progress. **Staff Interviews** Two of six staff interviewed (33%) 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. **Competency-Based Training and Performance Check-offs:** 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: o Methods to enhance communication o Implementation of programs o Benefits and use of AAC o Identification of non-verbal means of communication. While the NEO training appeared to meet basic standards, missing from the process was the presence of Speech Staff after the initial training at the homes to model and guide staff through real life activities and situations as needed. Thirty-six of 36 new employees (100%) had completed NEO core communication competencies for foundational skills and performance check-offs since the last review. **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 two individuals in Sample R.4 had received training related to Communication SAPs and programs. The Monitoring Team was unable to determine if all staff had received training due to the training sheets only having the names listed that had received the training and did not include those staff that still required training. Per review of Individuals #77 and #118, there was only evidence that five staff had received training on Individual #77's	

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		communication plans and only three staff had been trained on Individual #118's plans. Additionally, it should be noted that Individual #60's plans were not trained until October 11, 2013 although the need for training was identified during the 8/29/13 ISP. 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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. **Policy and Procedure** A Facility policy and/or procedure did 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 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 five individuals from Sample R.1 and the following was found: • For five of five individuals (100%), monitoring of communication supports was outlined in the assessment. • For zero of two individuals (0%) monitoring of their communication supports occurred at the frequency established by Facility policy or ISP. Three individuals were identified as not requiring monitoring and therefore only two were selected. 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 five individuals from Sample R.1 (0%) received monthly and/or quarterly	Noncompliance

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		monitoring to ensure all communication supports remained effective and functional. Monthly reviews by the QIDP were either missing or simply stated to continue with no information provided regarding if the individual showed improvement or decline with their skills. In order to move towards substantial compliance, RGSC must ensure review of communication strategies/goals/plans are reviewed by the QIDP with a particular mention of status of plans, and continued functional gains/support.	

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 (11/06/2013) 2. RGSC Action Plan (11/05/2013) 3. RGSC Presentation Book for Section S 4. Documents that were used as part of the document review process included the following. • For S.1, the ISP and SAPs were reviewed for Individuals #4 and #145 • For S.2, the facility tracking spreadsheets for assessment report submissions was reviewed • For S.3.a, the ISP and SAPs were reviewed for Individuals #4 and #145 • For S.3.b, community outing logs and the Facility summary of community-implemented SAPs were reviewed pertaining to the community training for Individuals #2, #3, #10, #11, #15, #19, #21, #24, #27, #31, #33, #48, #51, #55, #59, #60, #61, #65, #67, #72, #74, #76, #77, #79, #81, #82, #84, #85, #94, #101, #108, #127, #133, #134, #140, #143, #145, #149, and #150. **People Interviewed:** 1. George Romero – QIDP Coordinator 2. Approximately 15 direct care staff in residences, classrooms and vocational settings **Meeting Attended/Observations:** 1. ISP Annual Planning Meetings for Individual #74 2. The following residences and day treatment areas: All residence dining and activity rooms, vocational classrooms, and outdoor activity areas
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section S. 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 S, in conducting its self-assessment, the Facility: ▪ Appeared to use monitoring tools, as the Self-Assessment included percentages of compliance. The Self-Assessment however, did not include a description of the monitoring tools or the methodology for conducting the assessment. ▪ Described reviewing such things as records and the numbers of outings. The Self-Assessment did not provide specific information, however, about the sources of the information. ▪ The Facility consistently did not present data in a meaningful or useful way. Specifically, the Facility's Self-Assessment: o Did not present findings consistently based on specific, measurable indicators. Although the Facility reported percentage ratings of compliance, there were no specifics about how the ratings had been obtained. Without adequate information about how such ratings

	were made, it was not possible to interpret the ratings or reach conclusions about compliance with the Settlement Agreement. o Did not measure the quality as well as presence of items. For example, ratings consistently focused upon whether a specific format was used or if specific items were in the record. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with the following provisions of Section S: Provision S.3.b. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with no provisions. Regarding Provision S.3.b, although the Facility had made strides toward increasing skill acquisition training in the community, the skill acquisition programs lacked diversity and clear support from individualized assessments. 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, and Not Started. ▪ The Facility data did not identify areas of need/improvement. Rather, ▪ The actions did provide a set of steps focused toward compliance with the requirements of this Section. The provided steps, however, emphasized quantitative rather than qualitative efforts, limiting their utility in achieving compliance with the requirements of Section S.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RGSC from 11/17/2013 through 11/22/2013. Record reviews continued off-site 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. • The components of skill acquisition programs, such as consequences, discriminative stimuli, and opportunities for the target skill, had improved. • Functional engagement had continued to improve in relation to percentage of individuals engaged and the locations with greater than 50% engagement. • The Facility had substantially increased opportunities for skill acquisition training in the community. Despite the numerous areas of improvement, the Facility continued to demonstrate limitations or a lack of progress in several areas. • Skill acquisition programs were seldom based upon adequate assessment or information presented in the ISP. • Skill acquisition training programs often lacked a task analysis where appropriate, and did not provide an adequate number of training trials. • It was often unclear that assessment reports were completed at least annually.

	Based upon observations, record reviews, and other information obtained during the site visit process, it was not apparent that the Facility had ensured that individuals were provided with adequate assessment or training. Although improvements were noted in some areas, efforts toward compliance were often fragmented. If the Facility wants to ensure further progress, it will be important that efforts are closely coordinated and that qualitative measures are developed and implemented

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>S1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.</td><td>
<u>Historical Perspective</u>
During the baseline visit, 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, 13 of 13 individuals (100%) lacked assessments that could be shown to be accurate or that had identified real and meaningful needs. In March 2012, only marginal improvement was noted. During the August 2012 site visit, 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. Some modest improvement was noted in the reviewed SAPs. The May 2013 site visit revealed little improvement.

<u>Current Site Visit</u>
During the current site visit, the Facility provided one ISP with associated SAPs from each residence. From these, the first five SAPs as presented in the submitted documents were selected as the sample. This allowed for a sample of 10 SAPs.

<u>Use of Assessment Information in Planning Skill Acquisition</u>
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.

The table below reflects the status of assessments in relation to the sampled SAPs. Information in the table reflects modest improvement in relation to the use of assessments.

<table>
<tr><td></td><td>Baseline</td><td>5/2013</td><td>11/2013</td></tr>
<tr><td>Skill acquisition plans are implemented to address needs identified in:</td><td></td><td></td><td></td></tr>
<tr><td>ISP</td><td>0%</td><td>8%</td><td>20%</td></tr>
<tr><td>Adaptive skill or habilitative assessment</td><td>0%</td><td>8%</td><td>0%</td></tr>
<tr><td>Psychological assessment</td><td>0%</td><td>0%</td><td>20%</td></tr>
<tr><td>Skill acquisition plans are chosen in an individualized</td><td>0%</td><td>8%</td><td>40%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

manner.			
Skill acquisition plans are related to the individual's preferences.	0%	8%	40%

One of the 10 reviewed SAPs (10%) reflected the use of task analysis procedures in the development of the SAP. Not all teaching procedures require a task analysis. The sampled SAPs either included statements indicating the use of chaining procedures or the SAP targets were divided into steps. In either circumstance, a formal task analysis would be an essential assessment.

In 10 of 10 records (100%), documents reflected that each individual had been provided with skill assessment by means of the Functional Skill Assessment (FSA). It was not clear from a review of individual records and program documentation that the findings of the FSA had been effectively used in the development of skill acquisition programs or that the FSA was revised as indicated by data from training.

- Individual #145 was provided a SAP for hand washing. The SAP stated that the program was developed because of needs identified in the FSA. The FSA, however, indicated that the individual was independent in washing hands.
- Individual #4 was provided a SAP for flossing her teeth. The SAP indicated that the FSA was used to assess flossing and that the assessment supported the need for the SAP. The FSA does not include an assessment of flossing ability. Furthermore, the FSA indicated the individual was independent in dental hygiene skills.

Both individuals included in the sample had been provided a preference assessment using the Preferences and Strengths Inventory (PSI). This tool provides a subjective measure that relies upon self-report and staff observation regarding what the individual prefers in relation to residence, leisure, employment, diet, and numerous other areas. A large number of individuals living at the Facility experienced substantial deficits in communication skills. It was not evident from the preference assessments that vocal, gestural or other non-language-based communication was considered when identifying personal preferences. Furthermore, it was not evident that the Facility had made use of other means to identify personal preference with people experiencing communication limitations, such as systematic observations by neutral staff or providing the individual systematic opportunities to select or indicate preferred items. Rather, the preference assessments for individuals with limited communication routinely consisted of general, anecdotal statements of undocumented origin that could not be verified or validated.

Observations and record reviews also indicated other weaknesses relating to assessments and SAP development.

- Two of two individuals (100%) had been assessed with a standardized adaptive skill rating scale in the past year. Neither of the ISPs and none of the reviewed SAPs integrated results from the standardized assessment.

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- Individual #4 had previously been diagnosed with sensorineural hearing loss, a condition that can limit the ability to hear high frequency sounds. The individual in the past had refused hearing aids and indicated she could hear well. The IDT agreed the individual had functional hearing, as she was able to converse with others. Despite the individual's apparent functional hearing and awareness of the purpose of hearing aids, the IDT approved a SAP to teach the individual the purpose of hearing aids.

There were some examples of use of information from assessments in developing SAPs. As reported in Provision P2 for a sample of nine ISPs or ISPAs reviewed, in seven (78%), skill acquisition programs or opportunities for skill acquisition that had been recommended in the OT/PT assessment were present.

Teaching New Skills

The table below presents the status of the skill acquisition programs at the Facility. Although substantive improvement was noted in a few areas, the SAPs in general were little improved in comparison with previous visits.

	Baseline	5/2013	11/2013
Plan reflects development based upon a task analysis	0%	0%	10%
Behavioral objective(s)	0%	17%	10%
Operational definitions of target behavior	0%	17%	30%
Description of teaching conditions	0%	0%	0%
Schedule of implementation plans for sufficient trials for learning to occur	0%	0%	10%
Relevant discriminative stimuli	0%	38%	60%
Specific instructions	0%	8%	20%
Opportunity for the target behavior to occur	0%	33%	80%
Specific consequences for correct response	0%	21%	50%
Specific consequences for incorrect response	0%	13%	50%
Plan for maintenance and generalization that includes assessment and measurement methodology	0%	0%	0%
Documentation methodology	0%	4%	0%

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

Task analysis

One of the 10 reviewed SAPs (10%) reflected the use of task analysis procedures in the development of the SAP. For Individual #145, the SAP for crossing the street included three steps; look left, look right, and cross the street. The SAP did not provide criteria or instructions to assist in determining if the step was completed correctly. Furthermore, it was not evident that the SAP addressed all of the

#	Provision	Assessment of Status	Compliance
		components of the safe street-crossing skill. A task analysis, if completed correctly, would have provided such criteria, as well as provided additional steps for the appropriate actions involved in crossing the street. As written, the SAP did not provide the opportunity for effectively learning the stated skill. Behavioral objectives One of the 10 reviewed SAPs (10%) reflected behavioral objectives. Objectives should define the conditions under which the skill will be performed, the actions that constitute successful performance of the skill, and the criteria for measuring success. In addition, the objective should define a timeframe within which success is expected. For Individual #4, a SAP included the objective that she would successfully participate in the Chalupa game for 20 of 30 trials by 1/27/2014 – four months in the future. The objective specified the conditions, the behavior, and the success criteria. As the SAP specified that data were to be collected only once per week, the timeframe included in the objective did not allow the individual to succeed even if she displayed mastery from the first trial onward. Operational definitions Three of the 10 reviewed SAPs (30%) reflected adequate operational definitions. An operational definition identifies the components of the behavior in objective and measurable terms, provides sufficient clarity so that a naïve observer could recognize the behavior, and is sufficiently thorough so that the behavior and other similar yet different behaviors can easily be differentiated. Individual #145 was provided a SAP for shredding paper. The operational definition for the SAP was that the individual would complete all steps in the task analysis. This might have been acceptable if the steps had been objective, clear, and thorough. The program method, however, consisted of a single step that specified only that the individual would shred for 15 minutes. To be adequate, the step (or operational definition) should have included information that would make clear what constituted continuing shredding, such as the duration allowed between sheets fed into the shredder. Description of teaching conditions None of the 10 reviewed SAPs (0%) reflected an adequate description of teaching conditions. For a SAP to be implemented correctly there should be a description of where teaching will be conducted, how to arrange and present teaching materials, and how to provide an environment that is conducive to learning. Sufficient trials One of the 10 reviewed SAPs (10%) reflected sufficient trials for learning to take place. It has been repeatedly demonstrated in research regarding learning that the development of skills requires repetition. In the majority of cases, while the skill is initially being learned, high rates of repetition are required so that the individual is provided multiple opportunities for reinforcement. Often, lower frequencies of reinforcement result in slower rates of learning. If the rate for reinforcement opportunities falls too low in relation to a specific behavior, that specific reinforcement may not	

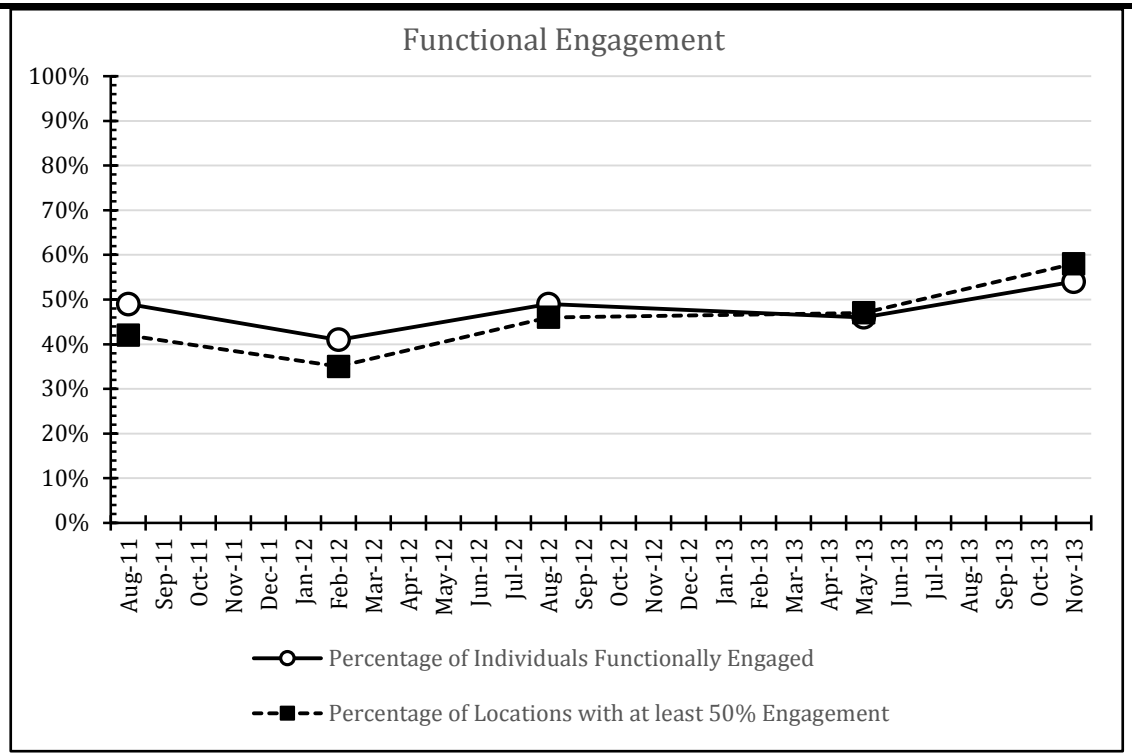
#	Provision	Assessment of Status	Compliance
		compete effectively and efficiently with other reinforcement in the environment. In the majority of skill acquisition programs reviewed at RGSC, the teaching trials were provided at a rate of one per day or less. A single trial per day is not usually sufficient to develop a new behavior or skill. <u>Relevant discriminative stimuli</u> 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 six of the 10 SAPs (60%), a specific prompt was to be delivered at the beginning of training that could have served as a discriminative stimulus. For example, in a SAP for Individual #4, staff were to begin training by stating, "It's time to learn about your diet texture". In the remaining four SAPs, no prompt or cue for training was described in the SAP. <u>Specific instructions</u> 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 10 SAPs (10%) included adequate instructions for staff. <u>Opportunity for the target behavior to occur</u> Eight of the 10 reviewed SAPs (80%) reflected the opportunity for the target skill to be performed. (The two SAPs that lacked this were the hearing aid SAP for Individual #4 and the radio tuning SAP for Individual #145). This was a substantial improvement over previous site visits. It must be noted, however, that the opportunity for a behavior to be performed does not ensure that the behavior will be performed or that the opportunity will occur in the context of a teaching program. A person could have a SAP to teach appropriate greeting skills. Through the course of a day, the person might experience a dozen circumstances in which the targeted greeting skills could be used. If staff do not implement the program according to instructions and document the training according to specific data collection procedures, there is no way to know if the program was implemented or if the targeted greeting skills were exhibited. Therefore, circumstances could allow for ample opportunities for the behavior to be displayed and yet training not include sufficient trials for learning to take place. <u>Specific consequences</u> Five of the 10 reviewed SAPs (50%) reflected specific consequences for correct and incorrect responses. Although this was an improvement over previous site visits, half of the reviewed SAPs continued to provide only non-specific instructions about how to deliver consequences. Consequences that were noted to be adequate were those that offered specific instructions for the delivery of a consequence, such as stopping the individual from selecting the wrong color and then using a gestural prompt to ensure the selection of the correct color. Those SAPs that did not include adequate consequences often lacked specific instructions. For example, Individual #145 had a SAP for shredding that included only the phrase "Verbal praise" in the instruction for consequences for	

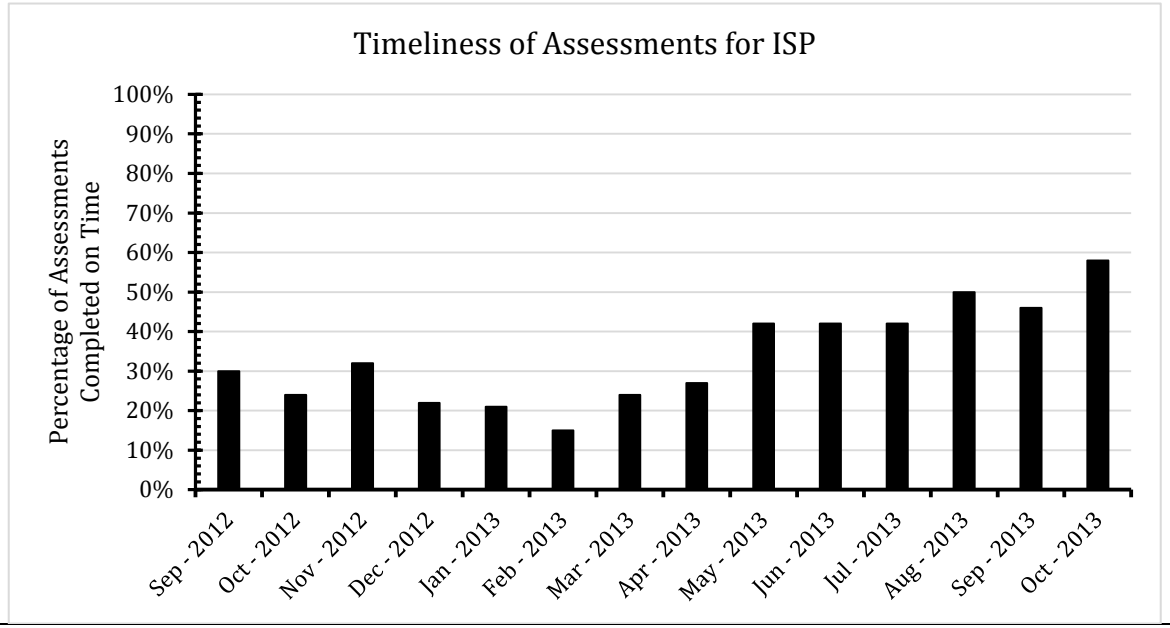
#	Provision	Assessment of Status	Compliance
		correct responses. There were no specific instructions regarding what constituted verbal praise or how it was to be delivered. <u>Documentation methodology</u> None of the 10 reviewed SAPs (0%) reflected an adequate documentation methodology. In order to 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 collecting data with sufficient frequency to ensure that a valid estimate of individual performance is achieved. The Facility was unable to demonstrate that an adequate data collection system was used. <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 10 the skill acquisition programs reviewed at the Facility (0%) included specific plans for generalization. <u>Promotion of growth, development, and independence</u> Despite some noted improvement, due to the limitations presented above, none of the 10 reviewed SAPs (0%) was likely to promote growth, development and independence. <u>Engagement, activities, and informal skill acquisition training</u> In addition to substantial weaknesses relating to skill assessment and SAP development, the Facility also demonstrated substantial limitations regarding the provision of active treatment. The Facility did have in place a system for monitoring active treatment or engagement that involved regular direct observation of individuals and activities, as well as a review of attendance records and community outing logs. Despite a considerable investment of time by the Facility, however, evidence did not reflect that this system consistently produced accurate information or resulted in adequate levels of engagement. For example, ratings of engagement were based upon 15-minute intervals. If an individual was engaged at any point during the interval, even very briefly, the interval was rated as engagement. Partial-interval data collection, the method of measurement used by the Facility, can provide valuable information. A 15-minute interval, however, was too long and was likely to produce substantial over-estimates of engagement. This was a probable explanation for the discrepancy between Facility ratings of engagement (consistently in the 80% to 90% range) and those obtained by the Monitoring Team. The Monitoring Team conducted observations in a variety of settings across the Facility. The table	

#	Provision	Assessment of Status	Compliance
		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
Vocational Room 3	1	4	2	50%
Vocational Room 16	2	7	3	43%
Vocational Room 17	1	4	0	0%
Vocational Room 18	2	5	4	80%
Vocational Room 12	1	4	1	25%
Vocational Room 11	2	3	2	67%
Vocational Room 21	1	3	3	100%
Vocational Room 25	3	6	4	67%
Vocational Room Rocks	1	6	6	100%
501 Dining	5	10	4	40%
502 Dining	8	8	7	88%
501 Lobby	1	4	0	0%
501 Activity room	1	3	2	67%
501 Activity room 2	2	6	2	33%
502 Patio	2	2	2	100%
502 Lobby	0	2	0	0%
502 Activity room	4	7	1	14%
502 Dining	3	7	5	71%
502 Patio	3	4	2	50%
502 Activity room patio	3	4	3	75%
Total percentage of individuals functionally engaged				54%
Percentage of locations with 50% or greater functional engagement				58%

Observations revealed that across all settings 54% of observed individuals were functionally engaged. Furthermore, more than half (58%) of all environments observed reflected at least 50% engagement. This constituted an improvement over the previous site visit when 46% of individuals were functionally engaged and 47% of locations reflected engagement of at least 50% of the individuals present.

#	Provision	Assessment of Status	Compliance
		 Specific positive observations included the following. • In Classroom 3, a staff member was working with two individuals on the budget for an upcoming outing. The staff made frequent reference to the individuals' interests and often used verbal prompts to facilitate decisions and actions. • One staff member was observed sitting outside residence 502 with two individuals. The staff was gesturing to various objects, such as birds and leaves, while presenting information about colors, shapes, and activities. The individuals were smiling and attending to the discussion. • In 15 of 20 observations (75%), staff were noted to use prompting. • In 10 of 20 observations (50%), materials were present and being used in activities. Not all observations conducted at the Facility reflected high levels of functional engagement. In a few settings, staff did not provide the materials and attention necessary to maintain reasonable levels of functional engagement. • In an activity room on residence 502, only one of seven individuals (14%) was engaged in a functional activity. One individual was asleep while a second individual was slumped over in	

#	Provision	Assessment of Status	Compliance
		a chair. A third individual was observed to eat shredded paper. • In an activity room on residence 501, only two of six individuals (33%) were engaged in any activity. Materials were in a box on the table, but no effort was made to use the materials or organize activities. The three staff present were watching television and talking between themselves. Based upon information obtained from the Facility, as well as observations and document reviews, it was reflected that the Facility had made improvement in limited areas, such as functional engagement and the inclusion of specific consequences in SAPs. Overall, however, there continued to be a lack of integration between assessment and skill acquisition programs, as well as broad weaknesses in the components of the SAPs. As a result, the available evidence indicates the Facility has not achieved substantial compliance with the Settlement Agreement in this area.	
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.	<u>Current Site Visit</u> Based upon tracking data maintained by the Facility, it was uncommon to have more than 50% 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.  	Noncompliance

#	Provision	Assessment of Status	Compliance
		Specific issues related to psychological assessments are presented in Section K of this report. Assessment limitations in addition to psychological and behavior assessment were also noted. • For three of six months (50%), Nursing assessments were not submitted in time for the ISP. • For three of six months (50%), Audiological assessments were not submitted in time for the ISP. • For three of six months (50%), Pharmacy assessments were not submitted in time for the ISP. • For four of six months (67%), Integrated Risk Rating Forms were not submitted in time for the ISP. • For five of six months (83%), Psychiatry assessments were not submitted in time for the ISP. • For five of six months (83%), Structural/Functional Assessments were not submitted in time for the ISP. Because multiple departments had not submitted assessment reports on time for the annual ISP, it was not evident that the Facility provided adequate measurement of individual strengths, skills, or needs on at least an annual basis. Although the Facility had improved the percentage of assessments that were submitted on time in comparison with the previous site visit, the percentage of assessments not submitted on time remained unnecessarily high. As a result, the Facility was determined to have not yet achieved substantial compliance with this provision of the Settlement Agreement.	
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)	Due to the limitations noted in Provisions S.1 and S.2, 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	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and</td><td>not possess a clear measure of each individual's strengths and needs, and could not develop, monitor or revise training programs with accuracy.

It is suggested that an SAP would be practical and functional if it a) could be implemented in locations where the individual was likely to live and work, and b) was likely to strengthen the basic set of skills the individual would need to succeed. In order to obtain a measure of practical and functional qualities of the SAPs at RGSC, the SAPs in the sample for Provision S.1 were rated on five questions. Those questions and the ratings are presented below.

<table>
<tr><th>Practical</th><th>Percentage of SAPs</th></tr>
<tr><td>SAP does not require excessive resources, time or staff.</td><td>90%</td></tr>
<tr><td>SAP is not excessively difficult or technical.</td><td>90%</td></tr>
<tr><td>SAP can be implemented in relevant environments.</td><td>90%</td></tr>
<tr><td>Functional</td><td></td></tr>
<tr><td>SAP addresses specific needs from formal assessment.</td><td>0%</td></tr>
<tr><td>SAP targets skills useful for the individual.</td><td>30%</td></tr>
</table>
None of the 10 sampled SAPs (0%) addressed specific needs from formal assessments. Three of the 10 sampled SAPs (30%) targeted skills that would likely be useful for the individual. An example in which a SAP was not functional is presented below.
• Individual #4 was provided a SAP to teach her the purpose of hearing aids. Although the individual did have some hearing loss, in the past she reported she could hear well and did not need to wear hearing aids. The IDT acknowledge that she could hear well enough to partake in daily activities and converse with staff and peers. As the individual had indicated knowledge of the relationship between hearing aids and hearing loss or difficulty, the SAP provided no functional benefit.

Based upon the information obtained during the current site visit, it was not apparent that the Facility was prepared to provide formal training that was functional for the individuals. It is recommended that the Facility enhance the integration between formal assessments and the unique needs of the individual.</td><td></td></tr>
<tr><td></td><td>(b) Include to the degree practicable training opportunities in community settings.</td><td>At the time of the current site visit, the Facility reported that 39 of 65 individuals (60%) had been provided skill acquisition plans that were to be implemented in the community. These 39 individuals included Individuals #2, #3, #10, #11, #15, #19, #21, #24, #27, #31, #33, #48, #51, #55, #59, #60, #61, #65, #67, #72, #74, #76, #77, #79, #81, #82, #84, #85, #94, #101, #108, #127, #133, #134, #140, #143, #145, #149, and #150. Due to four individuals having more than one community SAP, the total number of community SAPs was 44. Neither the actual SAPs nor the corresponding data</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		were provided for these 39 individuals; as stipulated in the document request, the Facility provided a summary of the SAP objectives and locations for each individual. Therefore, a comprehensive review of each SAP was not possible. Documentation provided by the Facility reflected that community SAPs targeted the following skills. • Money management was targeted in 36 of 44 SAPS (82%). • Safety skills, such as crossing the street, were targeted in four of 44 SAPs (9%). • Vehicle use skills, such as using a safety belt, were targeted in two of 44 SAPs (5%). • Physical fitness was targeted in one of 44 SAPs (2%). • Work skills were targeted in one of 44 SAPs (2%). It was positive that the Facility had implemented training in the community. The use of money, which was targeted in 82% of community SAPs, is an important skill. A variety of additional skills, however, can be equally important, such as identifying the correct restroom, identifying nutritional foods, identifying police and fire stations, and asking for directions. Budgeting for outings is also an important skill. Observations reflected one instance of informal budget training prior to an outing, noted above regarding an observation in Classroom 3. While the observed training was positive, circumstances would have been better if there had been SAPs and formal training for budgeting. It should be noted that 11 of the 44 SAPs (25%) listed for community implementation were over a year old at the time of the site visit. It was not possible to differentiate data collected at the Facility from those data collected in the community. The Facility reported that all data for each SAP were recorded on a single form.It was indicated by the Facility that SAPs implemented in the community were not limited to community implementation: the same SAPs were also implemented at the Facility. As a single data collection sheet was used for both community and Facility implementation, it was not possible to differentiate data from the two settings. The Facility reported that community outings were conducted on a routine basis. Documentation provided for four months reflected that outings occurred with the following frequency. • June 2013 – 36 outings • July 2013 – 41 outings • August 2013 – 40 outings • September 2013 – 32 outings Outings primarily centered on shopping, dining, and recreation, Shopping included Target, Walmart, K-Mart, HEB, Dollar General, and Family Dollar. Dining involved a variety of local restaurants, and recreation activities primarily involved a trip to a park. All trips were documented for date, time, participants, location, and activities. This documentation did not reflect the SAPs that were	

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		implemented during the outing. The Monitoring Team observed the annual ISP Planning meeting for Individual #74, whose LAR stated an interest in moving the individual closer to home. Involvement in community activities had been an action plan in the prior ISP. Review of a list of community activities engaged in by the individual indicated a high number of activities engaged in (a total of 84 in the prior year), but most of those were to a park or nature walk (52) or sports or soccer complex (11); one was to a restaurant, and four were to a museum or library. The Facility did not provide any evidence of skill acquisition training, nor was that discussed at the ISP planning meeting. At the time of the current site visit, no individuals were employed in the community. Individuals living at RGSC were not provided different SAPs for community implementation; during community outings, Facility SAPs were implemented in community settings. Therefore, weaknesses in SAPS documented in Provision S.1 applied to community as well as Facility training. RGSC should be commended for the effort required to initiate a large number of community training opportunities. In order to satisfy the Settlement Agreement, the individuals living at the Facility would benefit from an increased variety of skills to be taught. Of equal importance is the need for the Facility to ensure that skills adequately represent those abilities that will enhance independence and allow each individual to integrate with whatever community in which they choose to live.	

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 11/6/13 2. RGSC Action Plans 11/5/13 3. Provision Action Information for Section T 4. Presentation Book Section T 5. DADS Policy 018.2 Most Integrated Setting 10/18/13 6. DADS Policy 004.1 Individual Support Plan Process and attachments (11/20/12) 7. RGSC SOP ICF-MR 200 01 Most Integrated Setting (April 2011) 8. RGSC SOP ICF-MR 600 05 Admissions, Transfers, Furloughs and Discharges (April 2011) 9. Individual Support Plans (ISPs) and Supporting Documentation for Individuals #48 and #143. 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. 10. 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 11. 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 12. Since the last on-site review, a list of individuals whose referral has been rescinded, including the reason and all related ISPA documentation 13. 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." 14. For the past year, a list of all individuals who have died after moving to the community 15. For the last one year period, a list of individuals who had transitioned to the community and had police

	contact, psychiatric hospitalization, ER visit or unexpected medical hospitalization, unauthorized departure, transferred to a different setting, or returned to the Facility 16. 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 17. A current list of all alleged offenders committed to the facility following court-ordered evaluations 18. For the last twelve months, a list of all individuals who have been assessed for placement, date of assessment, and resulting recommendation(s) 19. 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. 20. Since the last compliance visit, copies of documents or written materials provided to staff to inform them of community living opportunities 21. Community Living Options Information Process (CLOIP) Documents for 28 Individuals, including Individuals #2, #4, #31, #35, #46, #60, #76, #127, and #149 22. ISP Addendums (ISPAs) addressing rescinded referrals for Individuals #118, #123, and #139 23. ISPAs for follow up meetings for Individuals #72 and #101 24. Community Living Discharge Plans (CLDPs) for Individuals #47, #62, #75, and #132 25. CLDP Checklist/Worksheet blank form (undated) 26. CLDP Checklist/Worksheet for Individual #132 27. 2013 Assessment Report for last three individuals who transitioned 28. Pre-Move Site Review blank form (September 2013) 29. Post-Move Monitoring Checklist blank form (October 2013) 30. Since the last on-site review, a list of all pre-move and post-move monitoring visits, including the dates of completed visits, for Individuals #47 and #75 31. For Individuals #47, #62, and #75: a. Pre- and Post-Move Monitoring Checklists completed by RGSC b. Individual Support Plan Addendums (ISPAs) for transition activities 32. Individual Support Plan Addendums (ISPAs) related to CLDP planning and visits to community homes for Individuals #47, #75, and #132 33. Since last on-site review, a list of all individuals returned from a community residential placement 34. Sample Transportation Checklist for visit of seven individuals to a group home on 10/9/13 35. Training/Course Sign-In Sheets for Provider Fair June 2013—Individuals, Providers, Families, and Staff 36. Family notifications on tours and visits to group homes 37. Email of 9/12/13 from Alma Ortiz, Admissions/Placement Coordinator (APC), notifying RGSC staff of tours for individuals to group homes and day habilitation programs 38. Agenda for State Office PMM meeting of 10/30-10/31/13 39. Post-Move Monitoring—Helpful Hints (October 2013) 40. Potentially Disrupted Community Transition (PDCT) Process (8/29/13) and ISPA template for PDCT (11/20/12) 41. Agenda, training materials, and Training/Course Sign-In Sheet for Transition Process Training of

	6/11/13 provided by State Office 42. Training materials and Training/Course Sign-In Sheet for Community Transition Process training of 9/10/13 provided by Alma Ortiz (RGSC Admissions/Placement Coordinator) and Armando Cobos (Transition Specialist) 43. Handouts and training rosters for training provided to RGSC staff by Tropical Texas Behavioral Health (Local Authority) 8/6/13 and 8/15/13 44. Reports showing analysis of monitoring/audit data or other data in relation to the provision of supports in the most integrated setting 45. Annual Report: Obstacles to Community Transition, Rio Grande State Center, Fiscal Year 2013 **People Interviewed:** 1. Alma Ortiz, Admission/Placement Coordinator (APC) and Armando Cobos, Transition Specialist **Meetings Attended/Observations:** 1. Post-Move Monitoring Visit for Individual #132 2. ISP Annual Planning Meetings for Individuals #74 and #84
	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. 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 Living Options Monitoring Tool ▪ The CLDP Monitoring Tool—the Facility did not provide the Monitoring Team with this tool, so comments below refer only to the Living Options Monitoring Tool. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. However, several applicable items on many of the tools reviewed were marked N/A or left blank; this was the case for items about strategies to overcome obstacles and about whether an assessment for community placement was completed pursuant to the current policy and was individualized. It appeared these were only completed when a referral was made. However, as noted in the findings for this section, these are important issues to be addressed for all individuals. 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 included adequate methodologies, which was review of the ISP. 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). This sample sizes were not

	adequate to consider them representative samples. Based on the sample size and number of individuals who had moved, the sample used was composed of only the individuals who had moved. Most requirements reviewed in the self-assessment were important for all individuals assessed, and the Facility stated the assessment was done at every ISP annual planning meeting. Therefore, a sample should have been taken from among all individuals who had an ISP planning meeting during the review period. o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. Some items were marked N/A on some tools and left blank on others; as noted above, some of these items should have been considered applicable. o The following staff/positions were responsible for completing the audit tools: The APD completed one reviewed tool; the Transition Specialist completed the remainder. o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were programmatically competent in the relevant area(s). o 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 data on participation in provider fairs and tours, and individuals who had Living Options discussions during ISP planning meetings • The Facility consistently did not present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Presented findings consistently based on specific, measurable indicators. However, this was limited to the use of the monitoring tools and to the participation and ISP data described above. The monitoring tool data were limited to the individuals who had moved, which did not address many of the requirements of the Section. o Consistently did not measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. It appeared that all data were collected by the program. • The Facility rated itself as being in compliance with the following provisions of Section T: Provision T1c1, Provision T1c2, Provision T1d, and Provision T2a. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with the following provisions: Provision T1c, Provision T1h, Provision T2a, and Provision T2b. The Self Assessment did not comment on Provision T2b. The Self Assessment documented noncompliance in the rating column for T1h but noted in the Status column that it was in compliance; for this provision, the parties had agreed that it would not be reviewed due to a history of compliance, and the rating of substantial compliance continued. For Provision T1c1, the Facility needed to ensure contact between facility clinicians and the clinicians who will serve the individual in the new setting, as appropriate. For Provision T1c2, the Facility needed to improve the identification of timelines for provision of supports. 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; one action was reported as Completed and ongoing. Several items listed as In Process had actually been completed in that a process was in place and would be continued, such as coordinating provider fairs twice a year and inviting families and LARs to tours for their family members. • The Facility data did not clearly identify areas of need/improvement and tie improvement actions to these areas. • For the most part, the actions provided a set of steps likely to lead to compliance with the requirements of this Section, but that was not consistently the case. For example, the exemplary action of inviting families and LARs on tours had already begun, but there had been no response; a sequence of actions might be identified in order to improve the response.
	Summary of Monitor's Assessment: RGSC continued to make progress toward planning for transition. It was less clear that progress was being made toward identification of obstacles to transition and addressing them, toward identifying the supports individuals would need, and toward timely completion of comprehensive assessments. The last compliance report stated that the Facility continued to make progress in encouraging and assisting individuals to move to more integrated settings and had continued to refer individuals for such movement. Since the last compliance visit, there have been both signs of continuing progress and signs that such encouragement and assistance has not maintained at the same level. The Facility needs to ensure that the annual assessments by professionals clearly state their independent determinations of the appropriateness of movement to a more integrated setting, as well as description of the supports that an individual would need. DADS had recently revised the statewide Most Integrated Setting policy. RGSC was in process of revising its local policy and should complete that soon and ensure it is consistent with DADS policy and addresses issues raised in this report. The IDT still failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, particularly since the teams often failed to appropriately identify the most integrated setting. The IDT needs to identify more comprehensively the obstacles to movement. For those obstacles that are identified, the IDT needs to develop individualized plans to overcome them. The Facility had taken actions to educate individuals and families/LARs, including providing individuals with opportunities to tour community settings and inviting families and LARs on tours to community providers along with their family members. The Facility must improve provision of individualized plans for education and should provide opportunities to learn about success stories.

	The process of developing Community Living Discharge Plans continued to improve, and evidence was provided of IDT involvement as the CLDP plan evolved during the transition process. The Facility should ensure individuals and their correspondents/LARs are involved throughout this process. It would be useful for the Facility to identify clearly when the initial CLDP development planning starts, so it would be clear whether it is timely. The Facility coordinated with potential providers during the transition process. Coordination included trial visits and assessment of those to help select a provider and training of provider staff prior to trial and pre-transition visits. CLDPs clearly identified who from the Facility and provider was responsible for each support. The CLDPs did not consistently identify clearly the timelines for implementation of supports. The documents provided did not consistently provide evidence that supports to be available on the day of move had been found to be in place by either the Local Authority or the Facility. Post move monitoring was timely and thorough. For one example in which a concern was noted, follow up action was documented.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into	The last compliance report stated that the Facility continued to make progress in encouraging and assisting individuals to move to more integrated settings and had continued to refer individuals for such movement. Since the last compliance visit, there have been both signs of continuing progress and signs that such encouragement and assistance has not maintained at the same level. <u>Policies and Procedures related to Movement to the Most Integrated Appropriate Setting:</u> The last compliance report also noted that DADS Policy 018.1 Most Integrated Setting prescribed procedures for encouraging and assisting individuals to move to the most integrated setting. As reported below in Provision T1b, this policy had been recently revised. It is important to continue revision of policies as needed. The Monitoring Teams will comment jointly as to whether the State policy adequately addresses all of the items in Section T of the Settlement Agreement. All facility-specific policies regarding most integrated setting practices remained the same as at the time of the last review, but the APC reported a draft of a revised policy was in process. <u>Transition Outcomes During Last Six Months:</u> • <u>Community Transitions:</u> o Three individuals had moved between the last compliance visit and the	Noncompliance

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	account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	beginning of the current visit; a fourth individual moved on the day this visit started. The total of four individuals represented 6% of the population. While this is less than the ten individuals who had moved during the previous period, it is a reasonable rate of movement. The Monitoring Team recognizes that rates of movement vary, and that efforts to encourage movement may take time to have effect. The Facility will need to demonstrate that this is a temporary reduction rather than a trend. o Review of document requests from prior visits indicated two of the four individuals who moved (50%) had been on the referral list more than 180 days. It should be noted that the Monitoring Team was extremely impressed that Individual #47 had moved and understands the lengthy process required to ensure the supports to address this individual's complex health and behavioral needs are in place. In addition, the APC reported that the individual who moved during the compliance visit had waited almost six months for an opening at the home the LAR wanted. • <u>Referrals for Community Transitions</u> o Five individuals (8% of the population) are currently on the list of referred individuals. Three of those were referred since the last compliance visit. The APC reported that three of these have been accepted by a provider; two are on hold pending resolution of medical issues, and one has a visit planned within the next month. This compares to eight individuals on the referral list at the time of the last compliance visit. o One individual has been on the referral list more than 180 days. The APC reported this individual had gone on a visit to a home, but the Facility had significant concern about the lack of adequate care provided at that home, and a decision was made to continue to look for other providers. From the information the APC provided, this seemed to be an appropriate decision. It is incumbent upon the Facility to ensure a potential provider can provide the supports identified in the CLDP. • <u>Outcomes of Transitions</u> o <u>Returns from Community Placement:</u> No individuals returned to the Facility following transition occurring since 7/1/09. o <u>Deaths Following Community Placement:</u> The Facility reported there were no deaths of individuals who had transitioned to a more integrated setting. o <u>Other Adverse Outcomes:</u> The Facility reported none of the following adverse outcomes had occurred since the last compliance visit. ▪ Psychiatric hospitalizations ▪ Emergency medical hospitalizations or emergency room visit	

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		▪ Unauthorized departure ▪ Transfer to another setting <u>Individuals requesting placement, but were not referred</u>: The Facility reported there were no individuals who requested placement but were not referred. Given the number of individuals for whom LAR choice was the reason for not referring (refer to Provision T1g for more detail), the Monitoring Team has some question about this. However, there was no evidence from observation of ISP annual planning meetings, from review of CLOIPs, or from review of ISPs that any individual had requested placement. <u>Rescinded Referrals</u>: The Facility reported that referrals for three individuals had been rescinded since the last review. Two were rescinded due to LAR request. One was rescinded due to pending medical issues. The Facility provided ISPAs that addressed the rescinded referrals. These decisions seemed to be reasonable. For one of two that involved LAR request (50%), the ISPA identified that issue being addressed and noted that, when stable, the IDT and LAR will discuss again. It should be noted that Provisions T1b1 and T1b2 refer to the IDT decision to remove of Individual #48 from the referral list; this individual was not on the list of rescinded referrals. The Facility must ensure that it accurately tracks removal of individuals from referral lists. <u>Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting:</u> The Facility had taken actions to encourage and assist individuals to move. These are described in Provision T1b2 and included tours of providers, a provider fair, and discussion at self-advocacy meetings. The continued involvement of the Transition Specialist has been positive. However, observation of the annual ISP planning meeting for Individual #74 was troubling. The individual's father had requested information on homes in the area where he wanted the individual to move and requested a list of providers in that area who could provide the appropriate level of service. The representative of Tropical Texas Behavioral Health (the Local Authority, or LA) stated she had sent him a list; he replied that she had sent a list of providers in the Valley (the area in which RGSC is located). The LA gave him a new list and suggested he contact providers, but he did not know which providers would have the needed services and asked, "What should I be on the lookout for?" Neither the LA nor facility staff offered to assist him in getting information, nor did they refer him to the LA in the area to which he wanted the individual to move. The Facility and LA put the entire burden of searching for a provider on the family, even after the father asked what to look for. It should be noted that the APC was not in attendance at this part of the meeting; she came later. At the end of the meeting, she offered help from the Facility in taking the individual to visits to possible providers and gave the family her	

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		phone number. Had she not done so, the Monitoring Team would have considered this an egregious example not only of not encouraging, but actually of putting barriers in the way of movement. The Facility should work with the LA to ensure families and LARs are offered assistance to get the information that would make them comfortable in finding and identifying possible providers. <u>Determinations of Professionals</u> In order for the State Office requirement to be met, each discipline's assessment needed to include an opinion/recommendation. In addition, at the ISP meeting, the IDT needed to make a recommendation to the individual/guardian. For the ISPs reviewed, the Monitoring Team found the required determination was still not being consistently provided. • Of the two ISPs reviewed, for neither (0%) did all of the assessments include the applicable statement/recommendation. Of 23 total assessments reviewed, only five (22%) included a determination of whether the individual could be served in a more integrated setting. • Two of two ISPs (100%) included an independent recommendation from the professionals on the team to the individual and LAR that the individual could be served in a more integrated setting, but neither (0%) made a referral. In reviewing CLDPs of those individuals who moved to a more integrated setting between the end of the last visit and the beginning of the current visit, none of them had opposed transition.	
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:	On 10/18/13, a month prior to this onsite review, the DADS revised Most Integrated Setting Practices policy was issued. The Monitoring Teams will comment jointly as to whether the State policy adequately addresses all of the items in Section T of the Settlement Agreement. All facility-specific policies regarding most integrated setting practices remained the same as at the time of the last review; the APC reported a draft of a new policy was in process. Facility-specific policy will need to be written and implemented based upon the new state policy. Facility staff indicated that they were in the process of reviewing the State policy, and revising Facility policies to reflect any changes. The parties agreed that the Monitors would rate T.1.b as just the development of an adequate policy. 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. RGSC SOP ICF-MR 200 01 Most Integrated Setting and RGSC SOP ICF-MR 600 05	Noncompliance

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		Admissions, Transfers, Furloughs and Discharges were not entirely consistent with the prior version of DADS policy. The last compliance report recommended that the Facility review its policy to ensure consistency; this recommendation remains, especially in light of the revised DADS policy. Due to the fact that the Facility had not yet finalized an adequate policy related to transition and discharge processes, the Facility remained out of compliance with this provision.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	<u>Protections, services, and supports:</u> DADS, DOJ, 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 Provisions F1d, F2a1, and F2a3. As documented in Provisions F1d, F2a1 and F2a3, the Monitoring Team found the IDT still failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, particularly since the teams often failed to appropriately identify the most integrated setting. Therefore, substantial compliance was not found for Provision T1b1. It is essential, as teams plan for individuals to move to community settings, that ISPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services. This is important for three reasons, including: 1) as individuals and their guardians are considering different options in the community, it is important for them, as well as potential providers, to have a clear idea about what protections, supports, and services the individual needs to ensure that perspective provider agencies are able to support the individual appropriately; 2) given the extensive histories of many individuals served by RGSC, it is important to have one document that summarizes the most relevant historical and current information about an individual to ensure that none of the important components of treatment are lost in the transition process; and 3) as the process progresses, the ISP will be the key document that is used to ensure that pre-move required supports are identified and in place prior to an individual's move, and post-move required supports are identified and provided in a timely and complete manner. <u>Identification of and Plans to Overcome Obstacles to Transition:</u> Of two sample ISPs reviewed, the Monitoring Team found that two (100%) had an obstacle defined: one indicated the obstacle was LAR Choice and one indicated the obstacle was Individual Choice. The IDT needs to identify more comprehensively the obstacles to movement, if any. Plans to address the identified obstacles at the individual	Noncompliance

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		level were not adequate. Of the two sample ISPs reviewed, neither (0%) included an action plan to address/overcome obstacles identified that was individualized, measurable, and comprehensively addressed the obstacles. Examples included: • Individual #143's preference for living options was described as unknown. The ISP narrative reported the guardian was opposed to community living. Her reasons were that she did not have confidence in group homes and felt the individual benefited from long term residence at RGSC and familiarity with staff. She also indicated the individual likes to wander away and she feared the individual might wander away from the group home. The Action Plan for Living Options was a Service Objective for the individual to visit new locations in the community through the retirement program. There were no Action Plans to address the guardian's specific concerns. • For Individual #48, the IDT determined the individual preferred to live at RGSC after reviewing responses to community group home tours and pre-placement visits. It was not clear how the behaviors referenced were differentiated from the individual's behavioral repertoire at the Facility, as described in the Structural and Functional Behavior Assessment and Positive Behavior Support Plan and other assessments prepared for the ISP. The IDT agreed to rescind the individual's referral, and stated an intention to continue group home tours, but with no specified frequency. The IDT also agreed to develop an Action Plan to implement a service objective to familiarize the individual with group homes to be toured by providing him with photos beforehand. This was an appropriate step, but there was no evidence the IDT had evaluated additional strategies that would adequately and comprehensively address the obstacle. There was no indication that specific behaviors were identified that were similar both in the responses to tour and visits and in the individual's behavior at the Facility, nor that action plans were established to address any of these behaviors. There was no discussion of the characteristics of the homes he had visited that may have contributed to his perceived negative responses. For example, there was no discussion regarding how the pre-placement tours may have been alternatively structured in terms of length, increased provider staff training and/or having familiar staff accompany the individual. It was also not clear the IDT had adequately addressed potential alternatives to group home settings, such as adult foster care, given the individual's preferences for smaller and quieter environments with fewer peers. <u>Preferences of Individuals and LARs</u> Of the two sample ISPs, neither (0%) included an adequate description of the individual's preference and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). See above.	

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	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	Provision of Adequate Education About Available Community Placements to Individuals and Their Families or Guardians to Enable Them to Make Informed Choices: In December 2011, the parties met and agreed to a set of criteria for evaluation of Provision T1b2. The Monitoring Team had the following findings for each of the criteria: An Individualized Plan For Each Individual: Development of individualized plans to educate individuals and LAR/families is challenging. The Facility did not yet succeed in developing individualized plans for community education and awareness, as evidenced by a sample of two recent ISPs for Individuals #48 and #143 (see detail in Provision T1b1). The Monitoring Team found the IDTs still needed to make a more careful assessment of the individual's specific need for education in this area. For neither of the two (0%) sampled ISPs reviewed was there an individualized plan for increasing awareness of community living options that adequately took into account the learning needs of the individual. Review of the ISPs noted the following: • Individual #48 had participated in several tours and trial visits to group homes and day habilitation settings. The individual did not seem interested in any of the homes, exhibited challenging behaviors, and at times would not get off the van. The IDT decided to remove him from the community placement list. The ISP stated a service objective would be implemented for staff to show the individual pictures of group homes and provide a photo album. This was not listed in the Action Plan, but "service objective for group home" was listed as a goal; the actual service was simply stated as "SERVICE OBJECTIVE," so there was no way to determine whether anything was implemented. Nevertheless, the ISP did document the implementation in the prior year of an individualized plan for the individual to engage in tours and trial visits. • For Individual #143, the individual's mother/LAR did not want to tour homes or to permit the individual to be referred. The IDT did not develop an individualized plan for further education of the individual and family. As reported in Provision T1a, the annual ISP planning meeting for Individual #74 provided an example in which a family was requesting information, but neither the Facility nor the LA took action to provide it. An annual provider fair that includes The Facility held provider fairs on 6/22/13 and 10/17/13. From review of the sign-in sheets, the June fair was attended by 26 individuals of the 62 in residence at that time (42% of the population), 10 staff, and nine providers (most with multiple staff participating). The October fair was attended by 33 of 63 individuals (52%), 10 staff, and seven providers. An encouraging finding for the October fair was that four family	Noncompliance

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		members attended. The Facility did not provide any information on outcome measures other than attendance, or on assessment of satisfaction. Such information would permit the Facility to determine what was helpful and was not, and to determine whether changes should be made to future fairs. <u>Regular RGSC meeting with Local Authorities</u> The APC and the response to the document request stated there had been no meetings between the Facility staff and LA. Note below, though, that the LA provided training for Facility staff. <u>Education about community options</u> The Monitoring Team observed the Admission (30-day) ISP planning meeting for Individual #28. A positive observation was that discussion was held about the individual moving back to a community setting. There was discussion of the family's concerns about group living. The Facility made clear the expectation that the individual would move to a more integrated setting in the future, and it was clear the family understood that and would consider alternatives. As noted above regarding tours, the Facility had invited families/LARs to accompany individuals on tours to provider settings. This new initiative provided an excellent way to introduce community services to families and LARs. The Facility did not provide information on how many families and LARs chose to accompany individuals on tours, their satisfaction with the tours and/or their concerns, or whether these tours led to changes in willingness of families and LARs to consider transition. The Facility should consider gathering that information to assist in determining how to improve the process. The major means to educate individuals, families, and LARs was the Community Living Options Information Process (CLOIP). The Monitoring Team reviewed the CLOIP documents for Individuals #2, #4, #31, #35, #46, #60, #76, #127, and #149. • The LA met or had telephone conversation with a primary correspondent or LAR for three individuals (33%). • The LA met with eight individuals (89%). The LAR for one individual requested the CLOIP information not be presented to the individual. • Of the eight individuals, six (75%) responded and expressed preferences or were otherwise responsive. The LA was present at both annual ISP planning meetings observed by the Monitoring Team.	

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		Tours of community providers The Facility provided a Transportation Checklist as a sample of documentation of a visit by individuals living at RGSC to a group home. Tracking was done by listing the individuals who were on the trip. For this trip, seven individuals were included. In addition, in interview, the APC reported on a trip for five individuals to visit someone who had transitioned at the individual's home and day habilitation site. The Facility also provided an email regarding a visit by two individuals to group home/day habilitation sites. This indicated the Facility also provides individuals a chance to visit and tour individually or in small groups and permits greater individualization. The Self-Assessment stated that 20 individuals participated in a community tour of alternate living environments between July 2013 and 10/3/13. As noted below, at least 31 tours were planned. The Facility also invited families and LARs (legally authorized representatives/guardians) to join with individuals on tours to group homes and day programs. The Facility provided copies of letters for 31 tours since the last compliance visit, including the tour for two individuals described above. The Self-Assessment reported that no family participated in a community tour. The Facility should continue to seek ways to encourage involvement of families and LARs in these tours. The Facility had a process in place to document an assessment of the individual's reactions during tours. Opportunities are provided to visit friends who live in the community: As noted above, the APC reported on a trip for five individuals to visit someone who had transitioned at the individual's home and day habilitation site. As noted in Provision U2, the Facility had continued self-advocacy training held jointly with Educare, a private provider of community living services. One of the individuals who participated in the Educare group had formerly lived at RGSC, and the RGSC participants could interact quarterly with this individual. No other information was provided about additional opportunities for individuals to visit friends in the community. Education may be provided at various venues As reported in Section U, RGSC had an active self-advocacy program, with a significant portion of the population attending most meetings. The minutes of the "Rough Riders" self-advocacy meeting of 8/28/13 documented that the primary topic for that meeting was "Community Placement." The meeting included a presentation by the Transition Specialist.	

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		The Facility did not report any other education activities, other than tours and the self-advocacy opportunity with Educare. <u>A plan for staff to learn more about community options</u> Tropical Texas Home Based Community Services (HCS) provided a training session for RGSC staff; several sessions were held to permit greater attendance from all shifts. The training included handouts, including descriptions of various IDD services and supports provided by DADS, how a provider is selected for programs, eligibility requirements for individuals, and questions to ask of providers. It was positive to find that the LA provided this kind of training to staff who may be involved in IDT decisions. <u>Individuals and families who are reluctant have opportunities to learn about success stories</u> The Facility did not report any presentations to a family association, newsletters, or other opportunities for individuals and families to learn about success stories, other than the tours and other opportunities already described in this provision. To achieve substantial compliance, the Facility must improve provision of individualized plans for education and should provide opportunities to learn about success stories.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	In response to a request for a description of how the Facility assesses an individual for placement, the Facility responded that the ISP is the tool for assessing an individual, that disciplines provide their recommendations for placement in their annual summaries, and that the IDT then comes to a consensus regarding referral. The ISP Meeting Guide requires a discussion of the "Living Goal" and of community awareness and education. A goal is to be determined, and an action plan to address needs to increase community involvement and awareness. Later in the meeting, a living options recommendation is to be made. Observation at the annual ISP planning meetings for Individuals #74 and #84 verified that these discussions were held. For two of two annual ISP planning meetings observed (100%), a thorough discussion of living options occurred. The Facility provided a list of ISPs held since the last compliance visit as evidence of completion of assessments of individuals for placement. To meet the requirement for assessment, however, each discipline's assessment needed to include an opinion/recommendation. In addition, at the ISP meeting, the IDT needed to make a recommendation to the individual/guardian. Review of two ISPs provided by	Noncompliance

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		the Facility, along with supporting documentation including assessments, found IDTs were making recommendations to the individual/guardian. • Two of two ISPs (100%) included an independent recommendation from the professionals on the team to the individual and LAR that the individual could be served in a more integrated setting, but neither (0%) made a referral. For the ISPs reviewed the Monitoring Team found the required determination by professionals was still not being consistently provided. • Of the two ISPs reviewed, for neither (0%) did all of the assessments include the applicable statement/recommendation. Of 23 total assessments reviewed, only five (22%) included a determination of whether the individual could be served in a more integrated setting. • Of the five assessments reviewed that did offer a recommendation, none (0%) included substantive and individualized recommendations for how the individual's needs could be met in a more integrated setting. A template statement in the assessment shell typically indicated the professional opinion was based on the current services and support being provided at the Facility and did not take into account that any different services might be needed in the community. Evidence that assessments included the professional's determination of appropriateness of moving to a more integrated setting was found in other reviews of assessments. The Monitoring Team reviewed this for Occupational/Physical Therapy evaluations and Communication/Speech evaluations. All evaluations (100%) provided statements about appropriateness. As described in Provision T1b1, the IDTs continued to lack proficiency in identifying 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.	
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	<u>CLDP Policy and process</u> DADS Policy 108.2 Most Integrated Setting had been implemented a month prior to this compliance visit. The Facility had not yet revised its policy. The Facility provided a blank CLDP Checklist/Worksheet to be used in developing a CLDP. This worksheet listed the required documents: discharge summaries (and required that documentation showing that summaries were reviewed and supports identified prior to the CLDP be attached), other required documents, records required from the "Master File," other needed information, and a copy of the CLDP meeting	Substantial Compliance

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	community living discharge plan in a timely manner. Such a plan shall:	invitation. At the last compliance visit, the APC reported that the CLDP process begins with a meeting within three weeks (usually 14 days) following referral; this timeline seems extended, and the Monitoring Team recommended the Facility consider shortening it and beginning the process more quickly. No information was provided at this visit indicating that any change had occurred to the process. DADS policy 018.2 requires that the IDT convene within 14 days after a referral for community transition to discuss a number of issues. The policy does not require that the CLDP be completed at this meeting. Attached to the policy was a CLDP shell, a format for completing the CLDP. This shell begins with a great deal of information about status, then community living data (including the names of clinicians and LA contact, residence and day program address and contact, and other contact information), assessments and summaries, personal preferences, a summary of transition activities, and then the lists of pre-move (essential) and post-move (nonessential) supports, followed by a description of monitoring activities, criteria for discharge, and agreements. <u>Timeliness of Development and Implementation of CLDP:</u> Four individuals had moved since the last compliance visit. Since one individual had moved shortly after the last visit, the CLDP process had been well underway already. Therefore, the Monitoring Team reviewed the CLDP process for the last three individuals who had moved (Individuals #47, #75, and #132). The Monitoring Team assessed timeliness based on whether there was evidence the IDT met to initiate the process timely and whether a CLDP draft was completed in time to be useful in identifying appropriate providers and settings. The Facility did not clearly identify when a referral was made for two of these three individuals, as the referral process had begun before the last compliance visit. For Individual #132, the earliest ISPA provided to the Monitoring Team was nearly a month following the referral; it did, however, report tours already taken by the individual's parents to identified possible providers, thus indicating that planning had already been in place. For all three individuals (100%), the CLDP was developed timely. 1. Planning for programming and living options had begun for Individual #47 more than a year before transition. ISPA meeting records were provided to the Monitoring Team for 2/8/13, 2/20/13, 5/23/13, and 6/6/13. These meetings	

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		discussed supports that would be needed, and the outcomes of tours and visits. The ISPA for 2/10/12 stated team recommended referral. During that meeting, a plan was made for tours, including supports to assist in preparing the individual and carrying out tours. An ISPA of 6/6/12 described a comprehensive review of supports the individual would need, both while at RGSC and in a more integrated setting. 2. For Individual #75, ISPAs were provided for meetings for 5/7/13, 5/22/13, 5/24/13, and 7/16/13. The meeting record for 5/7/13 included discussion of the individual's preferences and how that would affect selection of a provider. 3. For Individual #132, there was documentation of a lengthy process. In this case, the LAR had selected a provider on the date of referral. The final CLDP documented numerous contacts among the provider, the Facility, and the LAR throughout the time from referral until transition. Also, the Facility provided ISPAs from 5/22/13, 9/27/13, and 10/25/13 that documented discussion of supports, a trial visit, and training of provider staff. <u>Timeliness of Referral and Movement</u> Although the time from initial referral to move exceeded 180 days for all three individuals, the timelines appeared appropriate. For Individual #47, the individual's complex health and behavioral needs required both treatments and supports at the Facility and a well-planned provider selection and transition process. For Individual #132, the LAR was waiting for an opening for a specific provider, and the move happened rapidly when an opening was available. The Facility provided ISPAs for Individuals #72 and #101 who had been on the referral list more than 180 days. The documentation showed meetings had been held monthly since August 2013, and one meeting had been held in May 2013 for Individual #72. The ISPAs reflected consideration of appropriate transition and planning activities, including training needed for staff of homes where the individuals would have overnight visits and discussion of the outcomes of visits. <u>IDT Member Participation</u> Decisions on referrals were made at ISP meetings for three of three individuals (100%). Sign-in sheets for ISPAs provided evidence for two of three individuals (67%) that some members of the IDT were present at ISPA meetings; while not the entire IDT, the representation seemed appropriate to the topics of the meetings. For Individual #75, completed sign-in sheets were not provided to the Monitoring Team for most ISPAs; some IDT members attended the final CLDP meeting. Overall, the Monitoring Team considers the attendance to have been appropriate. <u>Development of CLDP in coordination with the Local Authority (LA)</u>	

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		The CLDPs documented involvement of the LA for two of three individuals (67%). Documentation was through sign-in at ISPA meetings discussion transition and through signing the CLDP. For Individual #132, there was no LA signature for ISPA meetings, but the LA did sign the CLDP. Although the Facility did implement the CLDP process and develop and implement comprehensive CLDPs, the Facility needs to ensure that assessments are provided within 45 days of transition so that the final CLDPs can be based on current information. Also, as noted below, not all requirements of the Settlement Agreement regarding CLDPs were met.	
	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 Actions Needed for Transition</u> The Facility had made efforts to improve identification of actions needed for transition. For all three individuals (100%), ISPAs documented transition visits to the new home and day program site. Many supports described actions that the Facility would need to take, such as training provider staff. Some ISPAs documented that training or other actions had occurred. The CLDP included a heading for actions the Facility needed to take on the day of move, primarily involving providing medications and enteral feeding formula, providing person property, and money to be sent from the individual's Trust Fund account. However, the CLDP shell did not include a section that listed transition activities, the staff responsible, and documentation the activities had been implemented; this information was not found in the CLDPs reviewed. One important activity that was not found in the CLDPs reviewed is contact between clinicians serving an individual at the Facility and the clinicians who will serve the individual in the new community. This is especially of concern regarding contact between the current and new primary care provider, but is also important when a very significant support is needed (for example, when behavioral supports are critical to a successful transition and adjustment to the new setting). There was evidence this had occurred in zero of three CLDPs (0%). <u>Coordination of CLDP with provider staff:</u> From review of CLDPs and ISPAs, it was evident that three of three individuals made visits, including overnight visits, to the new home and day program. For three of three individuals (100%), supports included staff training; provision of such training will be reported in Provision T1e. The Monitoring Team would like to note here that the pre-move site review documentation for Individual #132 included not only training rosters but also copies of the competency tests for the trainees regarding physical and nutritional management, an exemplary practice.	Noncompliance
	2. Specify the Facility staff	<u>Responsible staff identified for needed actions:</u>	Noncompliance

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	responsible for these actions, and the timeframes in which such actions are to be completed.	Three of three CLDPs (100%) consistently identified Facility staff for needed actions by name. <u>Completion timeframes for needed actions identified</u>: Two of three CLDPs consistently identified timeframes for completion/evidence support was available. For Individual #75, dates for nonessential supports were, with one exception, "ongoing and as needed." Given the supports to be provided, this likely meant they were to be implemented on the day of the move, which would make them essential supports, but this was not clear. A date was given in the support list for an appointment with a new PCP, but this was not copied to the Date Due column. Furthermore, for Individual #47, all dates were "Before 90 days of move in date." This may not have been appropriate for all post-move supports. As noted above, providing tube feeding needed to occur immediately. Similarly, seeing a PCP should occur shortly after the move, whereas seeing a specialist within 90 days may be adequate. To achieve substantial compliance, the Facility must continue to list the responsible staff and must carefully identify timelines for provision of supports.	
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	<u>Review of CLDP with Individual and, as appropriate, the LAR:</u> Two individuals were adults without a LAR. Neither was present at any ISPA meeting for which the Facility provided a meeting record and sign-in sheet. For Individual #47, one sign-in sheet documented the participation of an advocate from Disability Rights Texas. For both individuals, ISPA meeting records documented observation of their behavior and affect during visits to providers; for Individual #75, there was also documentation that the choice of providers was discussed with the individual, and Facility staff helped the individual make a decision. Nevertheless, although some individuals might not participate actively in the CLDP decision-making process, the Facility must provide rationale when they are not afforded the opportunity. For Individual #132, there was documentation of the individual's LAR participating actively throughout the process.	Noncompliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	<u>Timeliness of Assessments:</u> The Facility provided the 2013 Assessment Report for the last three individuals who transitioned (Individuals #47, #75, and #132). This table listed the individuals and their transition dates, and all the required assessments. For each assessment for each individual, the table provided the date the most current assessment was completed. The following table provides the percentages of assessments completed, and the percentage completed within 45 days of the date of transition. The table listed 26 assessments	Noncompliance

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Individual #	Completed	Completed within 45 days
#47	18 (69%)	3 (12%)
#75	14 (54%)	13 (50%)
#132	19 (73%)	2 (8%)

The Facility had a CLDP Checklist/Worksheet that listed the clinical and program assessments required and recorded the date each report was completed and received. It also listed other documents that would be needed by the receiving provider so they could be checked off when received. This checklist seemed to have utility for tracking completion and receipt of needed documentation. At the last compliance visit, the Monitoring Team was not provided the tracking log of assessments for individuals who transitioned and instead reviewed the assessments that were provided with the CLDP. The number of assessments provided ranged from four to seven. There appears to have been an improvement in the number completed, if not in timeliness.

To check that, the Monitoring Team checked the assessments provided with the CLDP packet for Individual #132. Eight assessments were included in the packet. Three of these assessments were not documented on the checklist as received at all (in fact, the Social Services Update was not listed as one of the 26 required assessments but was in the CLDP packet). All eight (100%) had been completed within 45 days prior to transition. A checklist was also provided with the packet. It listed the same eight assessments with the dates. It also listed an additional four assessments with no date or other indication they had been completed; of those, only one (the Vocational Assessment) was among the list of 26. The remainder were not on the list of 26.

For the checklist to be useful, all lists of required assessments should be consistent with each other, and the dates on the checklists and assessment logs must match.

<u>Adequacy and Comprehensiveness of Assessments:</u>
The Monitoring Team did not specifically address the comprehensiveness of the transition and discharge assessments for the individuals who had transitioned. Provision M3 does report findings from review of the nursing assessments for these individuals. The nursing assessments in the CLDP/discharge packets did not contain sufficient information such that the receiving agency could understand their present health status in order to respond to their health care needs. Assessments did not clarify what specific issues regarding the individual needed training, what specifically was to be covered in the training, and what competencies should be checked; the CLDPs and post move monitoring documents also did not identify clearly what was trained.

Issues raised in other sections of this report document need for improvement in

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		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.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	<u>Local Authority Continuity of Care Process:</u> As part of the document request, the Monitoring Team asked for a list of all pre-move and post-move monitoring visits, and completed checklists for the individuals who moved to the community. The Monitoring Team reviewed the documents provided for Individuals #47, #75, and #143. The Facility provided pre-move documents completed by the LA for zero of three (0%). <u>Pre-Move Site Visit Completed by Facility:</u> The Facility provided Pre-Move Site Review documents completed by the APC and Transition Specialist for Individuals #47, #62, #75, and #132. The Monitoring Team compared the pre-move supports listed on the site review to the pre-move (essential) supports listed in the CLDP for Individuals #47, #75, and #132. These were identical for Individuals #47 and #132, but the final three supports (all involving training of day hab/group home staff) were not on the site review document provided. Four of four facility site visits (100%) were documented as occurring before the transition date. The site review form used by the Facility changed before the site review for Individual #132, who was the last individual who transitioned. For Individuals #47, #62, and #75, the checks did not substantiate that there was evidence each support was in place. For many supports, a statement such as "before he moves to the home on (date)" or "A visual check will be done every pmm visit" was made. This was not the case for the form for Individual #132, on which the evidence to be checked was listed, and a checkmark was made to document the evidence was checked. Because some review forms did not specifically document that supports were checked, the Monitoring Team cannot affirm that pre-visit checks ensured essential supports were in place prior to transition. No transitions were scheduled to occur in the near future, so there was no opportunity to observe a pre-move site visit during this compliance visit.	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	There was not a written policy or process for quality assurance to ensure the (a) development and (b) implementation of the portion of the CLDPs for which the Facility is responsible. <u>Quality Assurance Processes to Ensure Development of CLDPs</u>	Noncompliance

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	implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	The Facility provided monitoring tools for living options review for 22 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 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. This was also the situation for the last compliance visit. To achieve substantial compliance, the Facility will need to document and verify a process that: • Gathers information from monitoring and other data that the Facility can use to determine status and identify issues needing to be addressed. • Summarizes the information gathered in a way that permits review of trends and current status, and maintains detailed information that can be used to guide improvement actions. • Demonstrates review has been done of this information. • Demonstrates that issues needing systemic improvement are addressed effectively. <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 accompanied 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	<u>Facility Annual Obstacles Report</u> The Facility provided an updated Annual Report: Obstacles to Community Transition, Rio Grande State Center, Fiscal Year 2013 for review. RGSC reported that, for FY 2012, LAR reluctance for alternate placement was indicated as an obstacle for a large number of individuals (22 individuals). Another significant barrier was lack of Medicaid/SSI funding due to an individual's legal and citizenship status (nine	Noncompliance

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	annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	individuals). The obstacle for the largest number of individuals was "Behavioral health/psychiatric needs requiring frequent monitoring by a psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff" which identified a total of 54 individuals. Note that individuals could have multiple obstacles that would need to be addressed, so the total number of obstacles is greater than the number of individuals residing at RGSC. Although the table listing numbers of individuals with specific obstacles listed 54 individuals with behavioral health/psychiatric needs requiring increased monitoring and/or supervision, the narrative under "Center Strategies and Actions to Overcome or Reduce Obstacles to Transition" stated there were "18 individuals that have significant challenging behaviors." It is important for the Facility to ensure the data are accurate and consistent. While it is likely that there are some individuals who have behavioral health issues requiring increased monitoring, review of individuals taking psychotropic medications found that all had positive behavior support plans targeting challenging behaviors. It is also important that the Facility identify those individuals for whom behavioral health issues and other issues that require supports and services are truly obstacles, meaning not only that the individual needs specialized supports and services (such as increased monitoring and staff supervision) but also that those supports and services cannot be found in the location the individual prefers. The Monitoring Team did not assess the appropriateness and accuracy of the Facility's determinations of obstacles for this report but provides this as a general caution. <u>DADS Annual Obstacles Report</u> On February 26, 2013, DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. In its last report, the Monitoring Team provided detailed comments on the Obstacles report, which explained both the positive aspects of this report, as well as the reasons for ongoing noncompliance. The annual obstacles report had not yet been updated since the time of the previous monitoring review, and, therefore, no new comments are provided here. As noted in the Monitoring Team's last report, improvements in data collection and analysis, implementation of revised ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained.	
T1h	Commencing six months from the Effective Date and at six-month	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The	Substantial Compliance

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	intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	substantial compliance finding from the last review stands.	
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	To evaluate post-move monitoring, the Monitoring Team reviewed pre-move and post-move monitoring visits for individuals who had moved since the last compliance visit. <u>Staffing</u> Alma Ortiz, Admission/Placement Coordinator, conducted post-move monitoring visits.	Substantial Compliance

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	monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	In addition, Armando Cobos, Transition Specialist, also conducted post-move monitoring visits. Both also conducted pre-move site reviews. Timeliness of post-move monitoring visits: According to the list of PMM visits conducted for the 3 individuals who had moved between 5/18/13 and 11/17/13, nine reviews should have been completed. Of the nine required visits, nine (100%) were conducted and eight of nine (89%) were documented as completed on time (the 46-90 day checklist for Individual #62 was undated). Locations visited: For the nine 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 (56%). The checklists appeared to document visits only to the residence for Individual #62. It should be noted that Individual #62 moved shortly after the last compliance visit. For the two individuals who moved more recently, five of six checklists (83%) documented visits to both day program and residence. Content of review/completed checklists: For the nine post-move monitoring visits reviewed, nine (100%) of the post-move monitoring reviews were documented in the proper format. The last compliance report stated that findings of PMM checklists consisted almost entirely of yes/no checks of the presence of supports and services. At this review, eight of nine checklists also had explanations or narrative for at least some of the items reviewed. One checklist for Individual #62 did not have narratives but did have a description of a concern and the follow up that was done by the APC and Transition Specialist. This was a significant improvement. One of nine checklists (11%) reported a need for follow up on a concern. One of one concerns (100%) had documentation on the checklist that the IDT met to discuss and resolve the concern. In response to a request for reports showing analysis of monitoring/audit data or other data in relation to the provision of supports in the most integrated setting, the Facility replied "None." It would be wise for the Facility to establish a process to analyze the findings of monitoring visits and other data regarding provision of supports following transitions as a means to determine whether there are systemic issues the Facility might wish to address with improvement actions.	

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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 Quality Assurance staff on a 7-day PMM visit for Individual #132. Visits were made to the residence and to the day habilitation site. The APC reviewed each support listed on the PMM checklist. It appeared that the APC checked each item of evidence identified on the checklist (and consistent with the CLDP). Although not required in the list of supports from the CLDP, the APC checked the list of medical providers and determined which appointments had been made and the dates scheduled.	Substantial Compliance
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals:	The Facility reported no alternate discharges.	Not Rated

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	(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.		

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-Assessment 11/6/13 2. RGSC Action Plans 11/5/13 3. Presentation Book Section U 4. DADS Policy 019 Guardianship 3/7/12 5. RGSC SOP ICF-IID 200 04 Process for Reviewing the Need for Guardianship (10/13) 6. RGSC SOP ICF-IID 200 09 Self Advocacy Program—The "Advocates" (10/13) 7. Determining Need for Guardian or Advocate tool/template (9/2013) 8. Determining the Need for Guardian vs. Advocate Instructions (undated) 9. Contact Log of efforts to attain guardians 10. Meeting records of meetings of "The Rough Riders" self-advocacy group 4/29/13, 5/15/13, 6/26/13, and 8/28/13 11. HRO SA-PIC monthly summaries since last compliance visit 12. Description of new advocate 13. Meeting record for the Guardianship Committee covering 11/7/13, 11/12/13, and 11/14/13 **People Interviewed:** 1. Vanessa Alvarez, Human Rights Officer (HRO) and Michael Gove, Patient Rights Officer (PRO) for Mental Health Services **Meeting Attended/Observations:** 1. Meeting of "The Rough Riders" self-advocacy group 11/20/13
	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. ▪ Used other relevant data sources and/or key indicators/outcome measures, including: o Number of individuals reviewed for guardianship during annual staffings from 4/4/13 through 1017/13 o Number of individuals at each priority level on the list of individuals needing a guardian or advocate, and the number of those whose ranking had changed o The number of individuals for whom guardianship had been renewed or was in process o The number of individuals admitted since the last compliance visit, and the number of those who had legal guardianship previously established o The number of self-advocacy training sessions by The Arc of Texas, and the number of individuals who attended the last joint self-advocacy meeting with Educare that included training materials provided by The Arc ▪ 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 measure the quality as well as presence of items. There was no measurement of the quality of review of the need for guardianship. However, the Facility reported lack of compliance with Provision U1 because there was not yet a finalized process to determine functional capacity (presumably, capacity to make decisions). When such a process is implemented, the Facility should assess quality of implementation of the process. ▪ The Facility rated itself as being in compliance with neither provision of Section U. The parties agreed the Monitoring Team would not review Provision U1 for compliance, and the noncompliance finding from the prior review stands. The Monitoring Team concurred that Provision U2 was not yet in compliance. 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 actions, such as to update the guardianship priority list on a semiannual basis and upon change of status, and to maintain documentation of efforts and contacts regarding guardianship, were actually in place and completed, but would continue to be done; because they are actually done and in routine practice, these should be considered Completed, and any further steps to track or use them should be identified and implemented. ▪ The Facility data identified areas of need/improvement and targeted actions to address those areas. ▪ The actions provided a set of steps likely to lead to compliance with the requirements of this Section. It was clear that many of these actions would need to be ongoing, and the Facility might want to identify the steps to implement the process and the steps to follow up to ensure the process continues, so it is clear when steps are completed although actions may be ongoing through the foreseeable future.
	Summary of Monitor's Assessment: The parties agreed the Monitoring Team would not monitor Provision U1 because the Facility had made limited to no progress due to the lack of capacity assessment. The noncompliance finding from the last review stands. Nonetheless, the Monitoring Team would like to note that the Human Rights Officer has been working with other Facility staff to develop and implement more careful assessment of capacity of individuals to participate in making choices, and has developed a process to identify individuals who may benefit from an advocate in the absence of, or as an alternative to, guardianship. The Facility continued to work diligently to find guardians for individuals at high priority of need and to obtain advocates for individuals for whom advocacy is determined to be more appropriate. Provision U2: The Facility had established a distinct Guardianship Committee for the ICF-IID program.

	This committee was new; training of committee members had begun. Several guardianships had been renewed, but no new guardians had been obtained. One new advocacy had been established. The Facility engaged in discussion with Legal Aide about seven referrals. Some of these individuals had already transitioned to a more integrated setting, but the Facility was assisting in establishing communication between possible guardians and Legal Aide. RGSC had continued the remarkable participation of individuals in the self-advocacy meetings. Not only did the self-advocacy group maintain attendance by a very high percentage of the individuals who reside at the Facility (with reports to SA-PIC documenting attendance of 40% to 62% of individuals), but also it was clear that individuals had experienced participation frequently. At the last compliance visit, many individuals were present but did wander and did not pay attention; from observation at the meeting held during the current compliance visit, many of these individuals had made progress in learning how to behave during such meetings and paid greater attention to the activities of the meeting. The Facility reported continuation of the collaboration for self-advocacy training with the Arc of Texas and Educare. Although not specifically related to obtaining guardians, these opportunities may assist individuals to gain skills at making decisions about their lives so that they can benefit from relationships with advocates.

#	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	The parties agreed the Monitoring Team would not monitor this provision because the Facility had made limited to no progress due to the lack of capacity assessment. The noncompliance finding from the last review stands. Nonetheless, the Monitoring Team would like to note that the Human Rights Officer has been working with other Facility staff to develop and implement more careful assessment of capacity of individuals to participate in making choices, and has developed a process to identify individuals who may benefit from an advocate in the absence of, or as an alternative to, guardianship.	Noncompliance

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	restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.		
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; this policy provided guidance and protocol as to obtaining LARs for individuals who may need one. RGSC SOP ICF-IID 200-04 had been revised in October 2013. Facility policy is consistent with the requirements of DADS policy. <u>Establishment of a Guardianship Committee</u> At the last compliance visit, the Facility had established the Joint Commission Ethics, Rights, and Responsibilities Team to be the Guardianship Committee. Since then, the Facility had established a distinct Guardianship Committee for the ICF-IID program; this committee was described in the revised SOP ICF-IID 200-04. The Facility provided a meeting record that covered 11/7/13, 11/12/13, and 11/14/13. This record listed committee members, including the HRO and PRO, a support specialist, a QIDP, an individual who resided at the Facility, clinicians, a volunteer/LAR, and the ombudsman at the Facility. This set of meetings covered the role of the committee, guardianship law, and how prioritization of need for guardian versus advocate was done. As this was the only meeting record, and the separate Guardianship Committee had only recently been approved and implemented, this was likely the only meeting the committee has had. At the next compliance visit, Monitoring Team will review the operation of this committee and its effect on obtaining guardians and advocates. <u>Efforts to Obtain LARs:</u> Based on review of a list of new guardianships attained provided by the Facility in response to a document request, the Facility had obtained guardians (LARs) for eight individuals since the last compliance visit. Six of these were renewals of guardianship. Two were guardians already established at the time the individual was admitted to the Facility. No new guardianships were attained. As of the Need for Guardianship list of October 2013, 13 individuals were in need of guardianship of 64 individuals on the list (20%). An additional 27 individuals (42%) were identified as needing an advocate; of these, eight individuals were identified as non-citizens, and it was noted that non-citizens are not able to have a guardian. The remaining 24 individuals (38%) had guardians. The addition of a category of individuals needing advocates clarified that the Facility did not believe all individuals needed guardians. As mentioned briefly in Provision U1, the Facility had developed a thoughtful process to identify individuals for whom an advocate might be more appropriate than a	Noncompliance

#	Provision	Assessment of Status	Compliance
		guardian, so that individuals could participate in decision-making to the degree appropriate. Although there had not yet been development or selection of a tool or systematic process to assess capacity to consent, this process to review appropriateness of advocate versus need for guardian was a positive step toward development of such a process. The Facility provided notice of one individual for whom an advocacy had recently been established. The Facility was making efforts to obtain LARs. • At the time of the last compliance visit, the Facility was continuing to make efforts to work with an attorney and judge to provide pro bono assistance and to reduce the cost to file guardianship applications. This process continued for a time, but it did not result in attaining guardianships. The HRO reported continuing to seek assistance from attorneys to provide pro bono services to reduce costs for individuals seeking guardianship. The Contact Log reported discussion with Legal Aide about seven referrals from the judge. Of those, three had transitioned from the Facility, one had obtained guardianship, and three had not returned phone calls. The HRO followed up with phone calls to the three who had not returned phone calls to Legal Aide and provided documents needed for establishing guardianship to Legal Aide. • The Contact Log reported the HRO attended several ISP annual planning meetings to discuss guardianship renewals with LARs or to facilitate discussion on whether the individual would be better served by an advocate or guardian. • The HRO and the Contact Log reported that the training from the Arc about self-advocacy had continued. At the last compliance visit, the HRO stated this training was also intended to assist in recruitment of community people to serve as advocates. Even with these diligent efforts, the Facility must be more effective at establishment of guardianship. The HRO and the Need for Guardianship list identified barriers such as the cost to become a guardian (which the HRO has tried to reduce through seeking pro bono services) and the fact that some individuals are not citizens and are not eligible to have a guardian. The Monitoring Team understands the difficulty of this and the need for assistance from DADS and others to address these barriers. <u>Self-Advocacy</u> DADS Policy 057 Self-Advocacy and RGSC SOP ICF-IID 200 09 governed the self-advocacy process. RGSC had continued the remarkable participation of individuals in the self-advocacy meetings. Not only did the self-advocacy group maintain attendance by a very high	

#	Provision	Assessment of Status	Compliance
		percentage of the individuals who reside at the Facility (with reports to SA-PIC documenting attendance of 40% to 62% of individuals), but it was also clear that individuals had experienced participation frequently. At the last compliance visit, many individuals were present but did wander and did not pay attention; from observation at the meeting held during the current compliance visit, many of these individuals had made progress in learning how to behave during such meetings and paid greater attention to the activities of the meeting. The meeting records documented that information about abuse, neglect, and exploitation was discussed four of the five meetings (80%). One other topic was the focus of each meeting. The topics documented in the meeting records for this period were Right to Privacy, Freedom of Choice, Rights Handbook, Privacy Notice and HIPAA, and Community Placement. As noted above, the Monitoring Team observed the meeting held during the compliance visit. The meeting was well attended, and participation had even improved since the last observed meeting. The HRO reported that she had been working with the officers to increase their leadership of the meetings, and this was evident. Minutes for meetings held since the last compliance visit suggested a similar practice occurred at each meeting. The Contact Log reported continuation of the collaboration for self-advocacy training with the Arc of Texas and Educare. The Contact Log documented a presentation by Arc to nine individuals from RGSC and 10 from Educare regarding employment, one presented to 10 individuals each from RGSC and Educare regarding community living, and a DVD presentation provided by Arc at a joint session scheduled for October (and reported by the HRO and the Self-Assessment to have been attended by 11 individuals from RGSC and 16 from Educare). The Self-Assessment reported a total of five trainings from the Arc of Texas; this total likely included three that occurred prior to the last compliance visit. The HRO reported these joint meetings would continue to be held quarterly. This remains an excellent opportunity not only for training on self-advocacy and experiencing community involvement but also has the potential to identify advocates for individuals who may not need guardianship but do need assistance in decision-making. These opportunities may assist individuals to gain skills at making decisions about their lives so that they can benefit from relationships with advocates.	

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-Assessment 11/6/13 2. RGSC Action Plans 11/5/13 3. Presentation Book for Section V 4. Provision Action Information for Section V 5. DADS Policy 020.1 Recordkeeping Practices 3/05/10 6. RGSC Health Information Management (HIM) new and revised policies a. RGSC Standard Operating Procedure (SOP) HIM 400-02-ICF Additions, Updates and Changes to the Unified Record 8/23/13 b. RGSC SOP HIM 400-07-ICF Documentation Guidelines revised 2/25/13 c. RGSC SOP HIM 400-08-ICF Symbols and Abbreviations 8/23/13 d. RGSC SOP HIM 400 14 Filing and Purging of Information Policy/Procedure revised 7/17/12, reviewed 2/4/13 e. RGSC SOP HIM 400-20-ICF ICF-DD Monthly Record Review 10/24/13 and Audit Tool Cheat Sheets 7. RGSC SOP HR 100-07 Compliance with Required Training/Performance Evaluations/Corrective Action Plans/Health Information Management Deficiencies Requiring Action revised October 2013 8. RGSC SOP ICF-IID 200-02 Restrictive Practices (10/2013) 9. RGSC SOP ICF-IID 200 04 Process for Reviewing the Need for Guardianship (10/2013) 10. RGSC SOP ICF-IID 400 14 Medical Care (7/2013 and 10/2013) 11. RGSC SOP ICF-IID 400-12 Dental Services, revised October 2013 12. RGSC SOP AC 20 – ICF Referral Consultation Report (approved 03/2013) 13. RGSC SOP AC 21.1 – Psychiatric Physician's Orders (approved 03/2013) 14. PNMT Nurse Post Hospital Assessment/Evaluation Form (approved 05/2013) 15. RGSC SOP NR 200-31 – Anticoagulation Therapy Protocols (approved 07/2013) 16. RGSC SOP ICF-IID 40 RGSC SOP 0-16 – Premedication for Medical and Dental Procedures (approved 08/2013) 17. RGSC SOP ICF-IID 400-16 Premedication for Medical and Dental Procedures (10/13) 18. RGSC SOP ICF-IID 400-17 – Oral Suction Toothbrushing (approved 08/2013) 19. RGSC SOP ICF-IID 400-18 – Hospice Services (approved 10/2013) 20. RGSC SOP NR 200-52 – Deep Venous Thrombosis Assessment of Risk & Treatment (approved 08/2013) 21. RGSC SOP QM 100.001 Quality Management Department (6/13) 22. RGSC SOP QM 100.14 DADS Quality Assurance Expectations (8/13) 23. List of new or revised nursing policies, procedures, and protocols 24. List of new or updated Facility policies since last compliance visit 25. List of persons responsible for management of records 26. List of persons responsible for auditing of records

	27. New Employee Orientation (NEO) RGSC New Employee Unified Record Training power point presentation and competency test 7/18/13 28. Table of Contents of Active Record 10/16-17/13 29. Table of Contents of Individual Notebook 10/7/13 30. Table of Contents Master Record 7/30/12 31. Training/Course Sign-In Sheet for Overtime/Documentation Expectations 9/11-12/13 32. Active Record Check-out Form blank 9/26/13 33. Active Record Check-out Forms for La Paloma unit for 11/19/13 and 11/20/13 34. Email of 9/19/13 from Leticia Gonzales with revised instruction sheet template 35. Change of Status (COS) Integrated Health Care Plan (IHCP) Form 10/30/13 with highlighted new information from the revised instruction sheet template 36. Compliance by Chart table of compliance, dated 11/17/13 covering audits conducted from April 2013 through September 2013 37. Record Audit Tools for 14 audits conducted in August 2013 and September 2013 38. ICF Monthly Delinquency Reports to the Settlement Agreement-Program Improvement Committee (SA-PIC) June 2013, August 2013, September 2013, and October 2013 (presented to SA-PIC 11/22/13) 39. SA-PIC meeting minutes of 10/24/13 40. Inter-rater Questions/Discussions Log and sign-in sheet 9/11/13-9/12/13 41. Audit Tool Cheat Sheet 9/13/13 42. Email from Leticia Gonzalez of 9/25/13 reminding staff of the Appendix D guidelines to be met for assessments and sign-up sheets confirming review by the Provision of Care committee 43. Deficiencies Requiring Action Report presented to SA-PIC in November 2013 44. Individual Support Plans (ISPs) and assessments for Individuals #48 and #143 45. 2013 Assessment Report for newly admitted individuals from July 2013-November 2013 46. ISP Assessments Tracking Log May 2013-September 2013 47. Settlement Agreement Provision V.4—Interview Tool for use of the Record completed by Angie Alejo as observation of an IDT meeting for Individual #8 **People Interviewed:** 1. Leticia Gonzalez, RHIT, Health Information Management (HIM) Director, and Laura Coronado, RHIT HIM supervisor for the Outpatient Clinic 2. Group interview of Juan Michael Gonzalez, Program Improvement Manager, George Romero, QIDP Manager, Rosa Sanchez, and QIDPs Karina Serratos, Rebecca Olivarez, and Daniel Perez 3. Mary Ramos, QA Director, Lorraine Hinrichs, ICF-IID Director, and Leticia Gonzalez, HIM Director **Meeting Attended/Observations:** 1. ISP Annual Planning Meetings for Individuals #74 and #84 2. Admission ISP meeting for Individual #28 3. Quarterly review for Individual #79 4. Records storage area at La Paloma
	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 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: ▪ Record audit tools including the Individual Notebook Audit Tool-Vocational, the Individual Audit Tool-Residential, and the Active Record Audit Tool ▪ Active Record Check Out Form ▪ V4 Observation Tool o These monitoring/audit tools included adequate indicators to allow the Facility to determine status of most compliance requirements for Provisions V1, V3, and V4 the Settlement Agreement. These audits did not identify whether documents in the record were current. For many requirements, other information was provided that could allow the Facility to determine compliance status. 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 included adequate methodologies, including audits of records and observations of meetings, 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. This sample size was adequate for record audits to consider them representative samples but were not adequate (as noted by the Facility) to evaluate use of the record in making decisions. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results, although reliability/interobserver agreement on audit tools needs to continue to improve; the Facility was addressing that already.. o The following staff/positions were responsible for completing the audit tools: Unified Record Coordinator, Clerk II, Outpatient HIM Supervisor, and HIM Director 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, although it was very close for the record audits, and the Facility was working on continuing to improve this. ▪ Used use other relevant data sources and/or key indicators/outcome measures. For example, the Facility assessed the percent of deficiencies identified during audits as requiring action, and the percent of actions completed, were reported. However, it was unclear how 100% of systemic issues were addressed through the deficiencies requiring action process, as there remained several areas of improvement that continued needing to be addressed ▪ The Facility consistently presented data in a meaningful/useful way, although more complete

	explanation of some items in either the Self-Assessment or other documents would have been helpful. Specifically, the Facility's Self Assessment: o Presented findings consistently based on specific, measurable indicators ▪ All data were gathered by the HIM department except for Provision V2, which was gathered by Quality Assurance. ▪ The Facility rated itself as being in compliance with 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 Completed or In Process ▪ The Facility data identified areas of need/improvement. For example, the Facility noted as an area of noncompliance in the Self-Assessment that the majority of deficiencies requiring action had not been corrected. The Action Plan provided actions to address this. However, the actions did not consistently provide a set of steps likely to lead to compliance with the requirements of this Section. For example, both the actions to address improving response to deficiencies requiring action were In Process and had been since before the last compliance visit. In fact, additional action had been taken between the completion of the Action Plan and the beginning of this compliance visit, but it was not listed in the Action Plan. The Facility should look at changes in processes and systems, should identify goals and desired outcomes, and should establish action steps to move from current status to achieving those goals and outcomes
	Summary of Monitor's Assessment: The Facility continues to approach substantial compliance with the requirements of this provision. The Facility continues to maintain a Unified Record that includes all required components and in which documents can usually be found. The Unified Record contained all required components. Because all filing is done by the Health Information Management department, there might be an expectation that all documents would be available in the record. This, however, would require that all documents be provided timely. The Facility had a rigorous audit process, but that had not resulted in availability of documents or improvements in compliance with Appendix D requirements. The Facility made extensive use of an electronic record system, the Clinical Work Station (CWS). That made documents accessible but was cumbersome to use. The Facility also made use of a share drive that was not considered part of the unified record but allowed information to be easily accessible to members of the IDT. Provision V1: The Facility maintained a Unified Record for each individual that included all required components. The Facility provided training during New Employee Orientation (NEO) to staff who document in the Unified Record. New Employee Orientation (NEO) training materials were revised in July 2013, including creating a competency test of knowledge; the Monitoring Team suggests the test be revised so it also includes testing of documentation. Active Records and Individual Notebooks were both secure and accessible to staff. Presence of required documents in the record remained high, and compliance with Appendix D requirements was stable but continued to need improvement. Records on the CWS 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. Some documents, such as some physician documentation, were printed so that a hard copy could be kept in the Active Record for easy access. Provision V2: Both DADS and RGSC had continued to develop new policies and processes; the Monitoring Team, in its review, discovered several that the Facility had not reported. The Facility should ensure it has an ongoing and accurate list of current policies. The Facility had made progress in improving the process for notifying and training staff on new and revised policies and had developed policies and procedures that are needed to guide compliance with requirements of the Settlement Agreement. The Facility had implemented procedures to determine the training needed for new and revised policies, to require competency tests when appropriate, and to track training. There remains a need to develop and implement facility policies for some sections of the Settlement Agreement requirements. Provision V3: The Facility continued to have 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 noted in the last report continue to be 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. To ensure issues needing to be addressed are evident and progress can be tracked easily, the Monitoring Team suggests the Facility review the data tracked and trended to identify the most important issues needing review by HIM and the Facility management. Provision V4: Records were accessible, but information from them was not consistently used in decision-making or in provision of services. Use of data and other information at ISP planning meetings was variable, with some reporting of objective data, some reporting of impressions, and some lack of knowledge of data that were available in the Active Record. There remained difficulties in timely completion of assessments.

#	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	Noncompliance

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		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 was revised regarding inter-rater compliance reviews and requirements for Deficiencies Requiring Action notices. Facility policies were consistent with DADS policy. <u>The Facility Maintains a Unified Record</u> The Facility maintained a Unified Record for each individual. The Unified Record at RGSC consisted of an Active Record, Master Record, and an Individual Notebook (the Me Book, separated by Residential and Vocational), Master Record, Overflow kept at the HIM department, 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. <u>Staffing and Responsibility for Filing in the Record</u> The Health Information Management (HIM) Department was staffed by a Director, a Unified Records Coordinator (URC), and two clerks. In addition, the HIM supervisor for the Outpatient Clinic (another component of the Facility) provided regular assistance,	

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		including conducting independent audits to determine reliability of audit recording. The URC position had become vacant in between the compliance visits and was in process of being filled. 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. <u>Training of Staff on Documentation</u> The Facility provided training during New Employee Orientation (NEO) to staff who document in the Unified Record. New Employee Orientation (NEO) training materials were revised in July 2013, including creating a competency test. The Monitoring Team was provided the training materials and a competency test, which had been added since the last compliance visit. The training materials provided information on important terminology, including the components of the unified record, inaccurate recordkeeping practices, falsification, record maintenance guidelines, and the approved abbreviation list; expectations of the unified record, including components; basic documentation guidelines (consistent with Appendix D); the prohibition on falsification; security of information and the requirement to log records out and back when taken from the chart room; the use of abbreviations, and HIM department responsibilities. There was no indication from these materials that there was any practice on documentation. The competency test consisted of several questions about the topics covered in the training. The Monitoring Team suggests that the Facility consider including in the training and in the competency test some of the actual types of documentation that the staff will be expected to do. The HIM director reported an additional training activity carried out as part of an improvement initiative to increase timeliness of document completion, particularly for assessments. The QIDP Manager retrained the QIDPs on expectations of document completion. This training consisted of description of a plan to first address August cited deficiencies, then to ensure all required reports/assessments are completed and submitted within expected timeframes, then to complete previously cited deficiencies until all have been completed and submitted. The Facility had a template for informing staff of new and revised forms. This template was revised in September 2013 to include who is to conduct training, what type of training is to be conducted, who will receive training, and the date of implementation. Although no information was provided on how such training was to be tracked, this	

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		seemed to be valuable information to include when revising or implementing forms. The Change of Status IHCP form provided an example of how this would be done. <u>Accessibility and Security of Records</u> Active records were kept in a locked room (chart room) in each of the two living units. Home staff were able to access the records as needed. 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 Active Records were both secure and easily accessible to staff, and that Individual Records were kept in places where they were readily available when not with an individual but were not easily visible to individuals who should not have access. As noted above, records were present and accessible. The Monitoring Team checked the accessibility and security of active records for Individuals #31 and #79. For both individuals, one chart was present in the chart room, and two charts from the active record were appropriately checked out. A checkout list was in each room with the active records. The Monitoring Team reviewed the checkout system at La Paloma. The checkout book was present. For sampled Individuals #31, #55, #79, and #108, all charts were present for Individuals #55 and #108; for both individuals, one chart had been checked out but never checked back in, although it was present. Some charts were present and others were not present for Individuals #31 and #79; for both individuals, all records that were not present were correctly checked out. While the Monitoring Team was checking the records, a staff came in and correctly checked out the chart. Following the observation, the Monitoring Team requested a copy of the check-out forms for La Paloma for 11/19/13 and 11/20/13. The forms showed check back in for the one chart each noted above as present but not checked in for Individuals #55 and #108 with date but not time of check-in. Availability of the Master Record was checked by observation at the HIM department of the record for Individual #31. This record was present and in good order. <u>Accuracy, Completeness, and Timeliness of Records</u> To determine whether Active Records were completed in compliance with Facility expectations and Appendix D of the SA, the Monitoring Team reviewed: • Audits conducted by the Facility in the months of August and September 2013 • The complete Active Record for Individual #31 • Compliance by Chart table of compliance, dated 11/17/13 • ICF Monthly Delinquency Report to the Settlement Agreement-Program Improvement Committee (SA-PIC) 11/22/13	

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		It was unclear whether the Facility provided a trends report that provided data on accuracy and on compliance with Appendix D requirements over time. The May 2013 Delinquent Assessment Report included a graph that showed chart audit compliance scores stable at 78% and above over 12 months (but the chart itself did not indicate what was measured to determine compliance). The more recent graphs were titled "Facility Assessment/Record Compliance Scores"; the HIM Director reported that a monthly indicator is the % of Appendix D requirements records are compliant with, and that may be what this graph represented. The scores on these more recent graphs continued to show a stable and relatively high compliance score trend. As noted below, these reports also included a table that reported the percent of Appendix D guidelines met; however, the data did not match the graphs, so it remained unclear what the graphs represented. Completeness of Active Record and Individual Notebook: All three components of the unified record were available for Individual #31 and as recorded on all 14 record audits. • Individual #31 was selected by computer randomization from among the individuals who had an ISP meeting in October 2013 and would therefore have records audited during November 2013. The Monitoring Team used these tools to conduct the audit, the same tools used by the Facility: o Active Record Audit Tools for Charts 1, 2, and 3 o Individual Notebook Audit Tools for Vocational and Residential The Audit Tools 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. The Monitoring Team checked for the presence of each item on the Audit Tools. Because many items recorded as N/A were marked that way because they were not required and were not present, including those in calculations of presence of documents might overstate the actual accuracy of the record. Therefore, the Monitoring Team calculated percent present with and without including the times marked N/A. The table below identifies the number of documents present including and without the Not Applicable Items. The percentages present were consistent with the	

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		percentages found at the last compliance visit. Record / Without N/A / Including N/A Active Record: 93% / 96% Individual Notebook--Residential: 91% / 92% Individual Notebook--Vocational: 92% / 92% • The HIM Monthly Delinquency Report for November 2013 reported the inter-rater agreement on presence of document for five records audited, but did not provide data on the percent of documents present. While it is important to ensure reliability across raters so that there can be confidence the data are accurate, it is equally important to report the actual findings of the audits so the Facility can assess whether there is a need to address issues needing improvement. This report also reported problems in timeliness of completion of assessments, an issue which has been addressed (see Provision V3 for more detail) but still remains problematic. This issue has also been identified in the Monitoring Team's findings for Sections M and R. • The audited records provided by the Facility did not include the data on presence of documents. It would be helpful if the Facility would provide whatever data on presence of documents are routinely reviewed by the HIM Department, the Quality Assurance (QA) Department, or SA-PIC. In general, the records were neat. There were no examples of torn pages or missing tabs, tabs were in the correct order, and all pages were readable. The Master Record was reviewed for Individual #31. All required documents appeared to be present, and the documents were filed neatly and were easily accessible. Consistency with Appendix D Requirements: As reported below in Provision V3, the audit form at RGSC not only listed all documents to be filed in the Active Records and Individual Notebooks, but also listed the Appendix D requirements to be checked in each tab of the record. In reviewing the record for Individual #31, each of these requirements was checked for each tab. For Individual #31, the following table provides the percent of rating Appendix D requirements as met with and without consideration of requirements not applicable for a given tab of the record. Many requirements were not applicable for a given tab. For example, the tab for Specific Program Objectives could not have entries in reverse chronological order due to all such sheets being replaced following implementation of the updated ISP. Also, gaps and legibility in handwritten documentation were not	

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		applicable when all documents in a tab were typed. Therefore, data from Monitoring Team review are presented both with and without Not Applicable requirements. The percentage for the Active Record was consistent with what was found for one individual audited at the last compliance visit and higher than found for the other individual. The HIM Monthly Delinquency Report for the audit conducted in October 2013 reported the percent of Appendix D guidelines met for July, August, and September 2013; the graph and table did not describe whether this included N/A items or whether this was for the Active Record or for the total of the Active Record and Individual Notebooks. The percent meeting Appendix D guidelines for July was 60%, for August was 67%, and for September was 73%. These figures are relatively consistent with the findings from the record of Individual #31 without including N/A documents. There was improvement from one month to the next, and the single Active Record for Individual #31 reflected continuing improvement. The compliance with Appendix D guidelines still reflected a need for improvement. A graph in the report to SA-PIC titled "Facility Assessment Compliance Score" provided data. In the Self-Assessment, this graph was provided below a listing of percentages per month from monitoring "to determine if records meet compliance with Appendix D." These percentages, over the 13 months (12 months in Self-Assessment updated with the October 2013 data in the SA-PIC report) reported a range of compliance from 78% to 91% with most months between 80% and 88%. The graph showed stable performance with a recent slight trend upward. However, the legend described this as "Assessmt. Compl. %," and the data did not match the table on Appendix D Guidelines Met described above. A separate graph provided by the Facility, "Key Indicator Compliance Scores," displayed "% Assmt Compl."; these data did match the Facility Assessment Compliance Score, thus verifying the Facility Assessment Compliance Score reflected assessments completed. Therefore, the Monitoring Team accepted the data reported in the paragraph above as the actual percent of Appendix D requirements found compliant in audited records The Compliance by Chart table provided the Facility with data on most Appendix D requirements. The table listed the requirements down the side and the identification number of each individual along the top, making a cell for each requirement for each	

Record	Without N/A	Including N/A
Active Record	91%	93%
Individual Notebook--Residential	65%	89%
Individual Notebook--Vocational	71%	87%
Total all charts	85%	90%

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		record. The legend stated that Y=Yes, N=No, and - =Not Applicable. However, every cell was filled with either a Y or N. There was no indication of what percent of tabs would need to be found to be in compliance with a given requirement in order to have Y entered into that cell on this table. Furthermore, many of the requirements listed on this table were not included on the audit form (see Provision V3 for detail), and HIM staff informed the Monitoring Team that the audit does not use the statewide monitoring tool that includes all the Appendix D requirements; therefore, the Monitoring Team did not learn how these data are gathered for entering onto this table. Nevertheless, the table has promise as a tool to inform the Facility of the status of compliance with Appendix D requirements. The table includes, for each month, the percent of compliance averaged across all audits. It also includes, across all months on the table, the percent of compliance for each requirement category; it might be useful to have this information month by month as well as overall, to provide some insight into trends. Timeliness of records: The cheat sheet instructions for the audit form did not require that most documents be current in order to be found present. There were some exceptions, such as a requirement that the ISP is due 30 days after the ISP meeting and must be current. Review of the audits provided by the Facility identified some items noted as not current and not rated present, but there was no tracking of the percent of documents that were current. Therefore, the Monitoring Team could not discern whether records were or were not generally current and timely. The report to SA-PIC included a graph of assessment compliance by discipline that showed wide variation across disciplines. As reported below in Provision V4, the Facility was addressing lack of timeliness of completing assessments. There were also graphs by discipline titled "Summary of Assessments Not Compliant by for (sic) Disciplines Below 90%" that reported on numerous documents, not only assessments. The Monitoring Team had difficulty interpreting these as it was unclear what the denominators were; for example, for QIDP, the heading indicated five records were reviewed, but for some months, the number compliant was as high as nine. Nevertheless, it does appear these provided information on timeliness or presence of documents other than assessments. <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	

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		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, were printed so that a hard copy could be kept in the Active Record for easy access. <u>Conclusion</u> As concluded in the last report, the Facility continues to approach substantial compliance with the requirements of this provision. The Unified Record contained all required components. Active records were in good condition. There was some evidence that almost all required documents were present for most individual records and that there were fewer errors in compliance with Appendix D requirements when compared to previous visits. To achieve substantial compliance, the Facility must clearly track the presence of required documents and compliance with Appendix D requirements, and must ensure assessments are completed timely.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	<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. The report of the last compliance visit describes the process at that time. Per interview with Mary Ramos, QA Director, Lorraine Hinrichs, ICF-IID Director, and Leticia Gonzalez, HIM Director, the process for training staff on new and revised policies had changed, with two new procedures in place. o SA-PIC identifies which staff are to be trained and who is responsible for training. o All training is competency based with questions, and the responsible person determines what the competencies are and how they will be tested. Training rosters go to the Competency Training and Development department, and the status is reported at SA-PIC till complete. These two actions responded to recommendations made in the last report. The Facility expects to do an annual review of each policy, but these have not been completed for this cycle. <u>Training on Policies</u> As noted above, SA-PIC identifies who needs to be trained and who is responsible for training. SA-PIC meeting minutes of 10/24/13 report that training rosters have been submitted to CTD, and that these need to be submitted within five days of training. No information on status of completion of training was documented in the minutes. The	Noncompliance

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		Monitoring Team did not review training to evaluate the appropriateness of the competency tests, nor to determine whether the staff required to be trained are being trained timely. 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. RGSC reported that 8 policies/forms have been newly developed since the last compliance visit, reviewed and approved by the Professional Staff Organization (PSO). o AC 20 – ICF Referral Consultation Report (approved 03/2013) o AC 21.1 – Psychiatric Physician's Orders (approved 03/2013) o PNMT Nurse Post Hospital Assessment/Evaluation Form (approved 05/2013) o NR 200-31 – Anticoagulation Therapy Protocols (approved 07/2013) o ICF-IID 400-16 – Premedication for Medical and Dental Procedures (approved 08/2013) o ICF-IID 400-17 – Oral Suction Toothbrushing (approved 08/2013) o ICF-IID 400-18 – Hospice Services (approved 10/2013) o NR 200-52 – Deep Venous Thrombosis Assessment of Risk & Treatment (approved 08/2013) In interview with the Director of Quality Assurance, the ICF-IID Program Director, and the HIM Director, the Monitoring Team was also informed of two policies that were approved on 11/21/13 but not yet implemented and two DADS policies updated within the last week but not yet updated at the Facility. In addition, the Monitoring Team in its review found several other policies (SOPs) that had been revised or newly implemented, including: o RGSC SOP ICF-IID 200-02 Restrictive Practices (10/13) had been updated. o RGSC SOP ICF-IID 200 04 Process for Reviewing the Need for Guardianship (10/13) o RGSC SOP QM 100.001 Quality Management Department (6/13) o RGSC SOP QM 100.14 DADS Quality Assurance Expectations (8/13)	

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		o RGSC SOP ICF-IID 400 14 Medical Care (7/13 and 10/13) o RGSC SOP ICF-IID 400-12 Dental Services, revised October 2013 o As reported in Provision V1, several HIM policies had been revised. o The Nursing Department reported revision or implementation of a number of policies, as listed in Section M. However, copies of these were not provided. The Monitoring Team is also aware of several DADS policies that have been developed or revised. These include: o DADS Policy 015.1 Dental Services 8/15/13 o DADS Policy 003.2-Quality Assurance 5/22/13 o DADS Policy and Procedures 007.3 Psychiatry Services 05/01/2013 o DADS Policy 009.2 Medical Services 5/15/13 o DADS Policy 010.3 Nursing Services 6/17/13 o DADS Policy 017 Habilitation, Training, Education, and Skill Acquisition 8/1/13 o DADS Policy 008 Behavioral Health Services Department (11/5/13, in process of implementation) o DADS Policy 018.2 Most Integrated Setting Practices 10/18/13 <u>Areas in which Efforts are Needed</u> In its last report the Monitoring Team noted that the Facility had two separate and distinct policies governing the use of restraint. These were 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 were not 100% congruent. For example, NR400-20 did not include the requirements associated with protective mechanical restraint for self-injurious behavior (PMR-SIB) required in State policy. The Monitoring Team suggested that the Facility should review each policy and make certain 1) all requirements of State policy are included, and 2) procedural requirements dictated in each policy are consistent within one another. This review had not occurred. Some of the problems associated with nursing follow-up reported in Provision C.5 could be attributable to inconsistent policy direction. Since the last review the Facility had updated its Quality Assurance policy and its Improving Organizational Performance Program document to include key indicators. While key indicators had been identified, and for most at least some data was being collected, this was a very new initiative requiring much refinement. The Facility PNM policy needed guidelines on the PNMT role in the Quality Review process and needed to address collaboration with Dental Services. Other essential areas were generally present. The Facility did not have a comprehensive OT/PT policy. It should be noted that RGSC	

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		was in the process of revising their OT/PT policy but this had not been completed as of this date. The Facility had made progress in improving the process for notifying and training staff on new and revised policies and had developed and policies and procedures that are needed to guide compliance with requirements of the Settlement Agreement. This progress needs to continue so that all areas will be addressed as needed.	
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 ISP planning meeting was held provides audit of 100% of records annually, which is acceptable. The HIM Director stated the practice is to audit the record for every individual who had an ISP planning meeting the prior month. If there were not five ISP planning meetings, they would audit the record for an individual who had one in the current month and would ordinarily be audited the next month. The Facility provided a Compliance by Chart table that provided results from a minimum of five and maximum of eight records that had been audited per month from April 2013 through September 2013. The Facility also provided 14 audits conducted in August and September 2013; the Monitoring Team verified these were for the same records reported on the Compliance by Chart table for those months. Audits were done of all charts in the Active Record and of the Individual Notebook for Vocational and Residential. The HIM Director stated there are no other components of the Unified Record except the Master Record. The audit process had one revision since the last compliance visit. At the time of the last visit, audits were done early in the month following the annual ISP planning meeting. This resulted in checking for presence of documents that were not yet due. Therefore, the audit time was moved to the last week of the month following the ISP meeting. <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	Noncompliance

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		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. Data on reliability were reported monthly to SA-PIC for each Active Record Chart and for the Residential Individual Notebook and the Vocational Individual Notebook. Reliability was presented for Documents Present and for Appendix D Requirements, and for the total for each chart. A graph was also provided. The table for the record audited for reliability in October 2013 reported agreement of 79% for documents present and 73% for compliance with Appendix D requirements. This was slightly lower than agreement on documents present in the other three months on the graph, and it was within the range of compliance on Appendix D. The HIM Director also audited the record audited by the Monitoring Team and reported in Provision V1. These audits were done on the same day. Considering only documents and Appendix D requirements for which at least one rater found it applicable, the Monitoring Team and HIM found the following agreement:	

Chart	Documents Present	Appendix D
Individual Notebook-Vocational	70%	88%
Individual Notebook-Residential	78%	57%
Active Record 1	93%	49%
Active Record 2	100%	87%
Active Record 3	82%	65%
Total	87%	67%

These agreement percentages are within the range reported by the Facility for Documents Present but slightly lower for Appendix D requirements. Similarly, these percentages are nearly the same as found at the last compliance visit for Documents Present but lower for Appendix D requirements. Review of the disagreements indicates that many of them were differences in rating whether documents were in reverse chronological order, with the Monitoring Team rating N/A and the Facility rating Yes; for at least some of the tabs, there was only one of each document. Had this item been in agreement, the percentages for Appendix D would have been within the range reported by the Facility and found at the last visit. The Facility should clear up the definition of this item.

Overall, the agreement levels for Documents Present were adequate to suggest audit data are accurate. The agreement levels for Appendix D did not quite reach that level. The Facility has taken actions to improve agreement.

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		• HIM developed an Audit Tool Cheat Sheet, as reported in Provision V1. • A monthly inter-rater discussion among the raters was initiated in September 2013. From that discussion, a discussion log was generated that documented the questions and issues discussed and the decisions made. These decisions could relate to definitions for the audits or to actions needed to improve recordkeeping, both of which were reported in the discussion log. <u>Audit Findings</u> As reported in Provision V1, the Monitoring Team determined, from the reports provided by the Facility, the percent of Appendix D requirements found compliant was in the range of 60 to 73%, although the Monitoring Team audit of one record found 85%. <u>Corrective Actions</u> 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 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 (DRA) report provided to SA-PIC in November 2013 listed many DRAs that had not been corrected. Most involved completing and providing documents such as assessments. These began back as far as December 2012, with most appearing to be from August, September, and October 2013 (but with many older). The Self-Assessment reported that of 146 DRAs opened for the monthly record audits for 3/2013-8/2013, 25% had been closed at the time the Self-Assessment was prepared. 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.	

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		The HIM Director reported that the process that had been in use at the time of the last compliance visit remained. The HIM department tracked DRAs until assigned corrective actions had been completed. Given the high percentage that had not been completed, the Monitoring Team did not review corrective actions/DRAs for the audits provided by the Facility. To attain substantial compliance with this provision, not only do the audits need to be done and be accurate (which appears to be generally the case and should improve as the actions to improve reliability take effect), but also deficiencies must be corrected and action should be taken to limit reoccurrence of deficiencies. The Monitoring Team recommends that the responsibility for correct documentation and for correction of deficiencies should lie with the staff who supervise documentation, as stated in Facility policy; the Monitoring Team cannot suggest that widespread personnel actions will be the best means to accomplish this but does suggest the policy either be followed or revised. <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 on completion of assessments and on compliance with Appendix D requirements were provided to the monthly SA-PIC meeting. Because the DRA report did not provide the DRAs chronologically, the Monitoring Team could not compare the percent of assessments completed (as shown on the graph) to the DRAs indicating noncompletion of assessments. The Facility had, however, identified lack of timely assessments as a systemic issue requiring attention, and had taken action. The HIM Director reported the Facility had implemented a database to track compliance with Appendix D indicators. The database tracks current assessments, complete assessments/assessments not authenticated with name and job title, and other information. From this, a percentage of compliance with 12 Appendix D indicators can be calculated. The HIM reported on systemic actions to improve compliance. These included: • Implementing assessment legends • Training at a QIDP meeting on expectations of document completion. A sign-in sheet for training in September 2013 was provided. Included on the sheet was a set of expectations provided to the QIDPs, including mandatory overtime to clear deficiencies and that failure to comply will result in implementation of performance actions. This training consisted of description of a plan to first address August cited deficiencies, then to ensure all required reports/assessments are completed and submitted within expected timeframes, then to complete previously cited deficiencies until all have been completed and submitted.	

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		The HIM Director reported the number of ISPs completed within 30 days post ISP meeting, for audited records, rose from 17% in August 2013 (with a range from 33% to 71% over the prior year) to 100% for September ISPs. The Facility should be sure to provide information to the Monitoring Team at the next compliance visit about the continuing effectiveness of this or any further actions taken to improve timeliness of assessments. <u>Conclusion</u> The Facility continued to have 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 noted in the last report continue to be 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. To ensure issues needing to be addressed are evident and progress can be tracked easily, the Monitoring Team suggests the Facility review the data tracked and trended to identify the most important issues needing review by HIM and the Facility management, and prepare reports that are clear, and tables and documents that have clear headings or legends that specify the data being provided.	
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. <u>Records are Accessible to Staff, Clinicians, and Others</u> As reported in Provision V1, Active Records and Individual Notebooks (Residential) were readily accessible. In general, records could be produced when requested, with some exceptions. As reported in Provision V1, the check-out book at La Paloma documented accurate check-out of records that were not present. Some records that were present had not been checked back in. The Self-Assessment reported that eight of 36 individual records (22%) were not readily accessible at the time of the audit and were not checked out properly. The Self-Assessment also reported that audits of the active record check out log were conducted monthly and showed 86%-95% compliance from May 2013 through September 2013. Thus, the check-out system works reasonably well but still needs more accurate implementation.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Share Drive made assessments readily available to clinical staff, residential directors, QIDPs, and others who might need to refer to them. There were difficulties in gathering information for clinical decision-making and use of health care plan instructions by DSPs, as reported in Provision M1. • The CWS made accessible IPNs and certain assessments, but the process to review those could be somewhat cumbersome. 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. • RGSC had begun to include the Direct Care Professional Instruction Sheets related to the Integrated Health Care Plans in the Individual Notebooks. However, these were not consistently found in the Individual Notebooks for the individuals sampled. For more information, refer to Provision M5. Although the Monitoring Team observed that although records were accessible, they were not always complete and used in delivering services and supports. For example: • As reported in Provisions F1d and S1, assessment information was not consistently used in making decisions during ISP annual planning meetings. • The ISP Guide for Individual #84 included information that the skill acquisition plan for requesting clothing was not found in the "ME book" (individual notebook) when a clinician conducted monitoring in early November 2013, nor had data sheets been placed in the book. • 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> Review of the audits provided by the Facility identified some items noted as not current and not rated present, but there was no tracking of the percent of documents that were current. Therefore, the Monitoring Team could not discern whether records were or were not generally current and timely. For assessments to be used in the annual Individual Support Plan (ISP) process, they must be completed and posted timely to permit the entire interdisciplinary team (IDT) to review them. To check whether assessments were completed and posted timely, the Monitoring Team: • Reviewed the Facility's assessment reports for ISP planning meetings conducted since the last compliance visit until September 2013	

#	Provision	Assessment of Status	Compliance
		• Reviewed the 2013 Assessment Report for individuals admitted from July 2013 until the compliance visit • Reviewed a sample of two Individual Support Plans (ISPs)—one selected by the Facility from El Paisano and one from La Paloma The report to SA-PIC included a graph of "% Assessment Compliance by Discipline." There was no indication whether this was of timeliness or also included other requirements such as signatures. Therefore, the Monitoring Team did not use this graph in evaluating timeliness. Assessments for the ISP were still not routinely completed on a timely basis. In the current ISP procedure, the IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting. There was evidence the IDTs had begun making use of this function, as both (100%) recent ISPs clearly defined the assessments that were to be completed. Findings included: • In a sample of two recent ISPs reviewed, neither (0%) had all assessments included and completed on a timely basis prior to the ISP annual meeting. Overall for this sample of 23 assessments that were required to be completed 10 working days prior to the ISP date, 11 (48%) were completed on a timely basis. The Facility provided tables titled Assessment Report for each month from May 2013 through September 2013. The assessment reports listed all assessments down the side and, for each individual, gave the date the assessment was completed. The reports provided a percent of assessments completed timely. For ISP planning meetings held in June, July, August, and September 2013 respectively, the percent of assessments completed timely was 42%, 42%, 50%, and 46%. The reports also provided a percent of assessments completed by the date the report was developed in the following month; these were respectively 73%, 73%, 77%, and 75%. Because a new process of identifying required assessments at pre-ISP meetings had been implemented, these figures may have been lower than the actual percent of required assessments; some assessments that were not required may have been counted as not provided (and, therefore, not timely). These data on timely completion of assessments differed from the Key Indicators graph of percent of assessments completed. For the months of June, July, August, and September 2013, this graph and the table below it reported 82%, 86%, 85%, and 88% of assessments completed. The dates of review might have been different from the dates of review for the Assessment Reports. Still, it would be both more efficient and more useful for the Facility to have one set of accurate data to review to determine status. In any case, even these higher percentages indicate some need for improvement.	

#	Provision	Assessment of Status	Compliance
		The assessment report for new admissions also listed all assessments down the side and the dates assessments were completed for each individual. Admission assessments are due five working days before the ISP. Based on the ISP dates on the assessment report (and considering only clinical assessments needed in advance but not rights assessments, water safety assessments, and other assessments not typically done in advance of the ISP meeting), for the seven individuals listed, percent of assessments completed timely ranged from 16% to 36%. Considering assessments completed by the date of the admission ISP, the percent ranged from 46% to 89%. No individuals had an audiology assessment or dental assessment. Only three of the six individuals (50%) had a nursing assessment, no nursing assessments were timely, and one was completed more than a month following the admission ISP. Another example of lack of timely documentation was reported in Provision M5, while touring La Paloma with the Nursing Operations Officer and QE Nurse, the Monitoring Team attempted to locate the Direct Care Professional Instruction Sheets in the "Me Books" for Individuals #36, #150, #126, and #4. None of the Direct Care Professional Instruction Sheets were found in the "Me Books" as required. The Nursing Operations Officer was asked to check on all eight individuals selected for review to determine whether Direct Care Professional Instruction Sheets were developed and implemented and/or just not in the "Me Books". After some investigation by the Nursing Operations Officer, he reported that the Direct Care Professional Instruction Sheets had not been developed and implemented for any of the eight individuals. Upon this discovery, the Nursing Operations Officer promptly conducted a meeting with all four RN Case Managers and instructed them to correct the problem immediately. <u>Data are documented/recorded timely on data and tracking sheets</u> In general, data were documented timely. For example, as reported in Provision M5, bowel monitoring data were found in the Active Records for several individuals and reviewed daily by the nursing staff. This was an improvement since the last compliance visit. There were, however, issues of completeness of the documentation. For example, issues with the Aspiration Trigger Sheet included: • The trigger sheet contained multiple gaps in data due to lack of completion. • Triggers when occurred were not consistently documented on the trigger sheet. Lack of timely documentation increases the likelihood of error. As reported in Provision K4, staff was permitted to wait until the end of the shift to record target and replacement data. Allowing prolonged delay between observations and data recording was likely to lead to errors in recorded data.	

#	Provision	Assessment of Status	Compliance
		Staff surveyed/interviewed indicate how the unified record is used The Facility had a process to survey staff regarding use of the Unified Record. This process was described in detail in the report of the last compliance visit. Because of the vacancy of the URC, this survey was not completed and reviewed since June 2013. The report of the last compliance visit commended the Facility for an effective survey process that included not only thorough review of the survey responses but also comparison of those responses to the chart audit findings. This comparison found discrepancies between some survey responses about documents used compared to the audit findings that those documents were not in the record. The Monitoring Team looks forward to the Facility's resumption of this process and the findings and actions that may result. Observation at meetings, including ISP meetings, indicates the unified record is used and data are reported rather than only clinical impressions The Monitoring Team observed ISP annual planning meetings for Individuals #74 and #84, and a quarterly review meeting for Individual #79. The Active Record was present at all three meetings. There were examples of use of information from the record and also examples in which impressions were given without reference to such information. • For Individual #74's current goals of making bed and brushing teeth, staff reported the individual was doing well but gave no data, indication of step of the task being taught currently, or description of whether there had been progress or had been revisions to the skill acquisition programs. The nurse case manager stated she would need to look up the number of seizures the individual has had; this information is important for decision-making at the meeting and should have been provided to all IDT members. This was particularly true as the individual's father expressed concern about a significant increase in seizures. The record was used to look up the date of the most recent hearing test. • For Individual #84, discussion of the Integrated Risk Rating Form (IRRF) involved review of a great deal of clinical data in specific risk areas. When a question arose about "food stealing," rates of this behavior and dates of occurrence were provided immediately. Data were reported on target behaviors and compared to baseline levels; although data were not reported on replacement behaviors, these were reported to be above baseline. • At the quarterly review for Individual #79, the Active Record and Residential Individual Notebook were present and were used extensively. In addition, the psychology assistant reported information from a review of the Client Work Station documents (CWS, the electronic record). Information was provided on an increase in vomiting and information found in the record that led to action. A consultation report found in CWS was not yet filed in the record; HIM department was called and brought the report so the IDT could review it.	

#	Provision	Assessment of Status	Compliance
		In addition, the HIM department provided one example of observation of an IDT meeting to assess the use of the record. A HIM staff observed for use of the record by six disciplines including direct services and the QIDP. She recorded on the Settlement Agreement Provision V.4—Interview Tool for use of the Record. She documented that one of the six discipline staff (17%) referenced the paper record but also noted that an additional four (67%) referenced their own notes and the QIDP, in addition to referencing information on her own notes, also reviewed information on the computer "to navigate throughout the whole meeting." She reported that the observation indicated the record is used when making decisions by five of the six (84%, all except direct services staff).	

List of Acronyms

Rio Grande State Center
November 18-22, 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
BSC	Behavior Support Committee
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
DRA	Deficiencies Requiring Action
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
LTAC	Long Term Acute Care Facility
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
MTC	Mealtime Coordinator
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
PCA	Program Compliance Auditor
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
PMR-SIB	Protective Mechanical Restraint for Self-Injurious Behavior
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)
PRP	Polypharmacy Review Panel
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