United States v. State of Texas

Monitoring Team Report

Rio Grande State Center
May 19-23, 2014

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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 a 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, Sandra Canales, and the staff who assisted her to keep up with all our requests, especially Rosa Sanchez, Alondra Machado, Elsa Morales, Leticia Gonzalez, Angie Alejo, Mary Lou Martinez, Gary Sauceda, Andy Garcia, Belinda Portales, Patricia Coronado Ismael Estrada, Ruby Garcia, and Alma Tapia. 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 66 individuals.

Facility Self-Assessment. 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. If the Facility intends to use its Self-Assessment to conclude whether it is in substantial compliance, it must identify and factor in all of the criteria upon which compliance is to be based. It may choose to prioritize only certain components in its Action Plan, but it should be aware that the prioritized activity might not be sufficient in achieving substantial compliance.

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. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.

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. This review included a 100% sample of crisis intervention restraint. This included one physical hold and five chemical restraints. During this review the Monitoring Team observed noticeable regression in compliance with long standing policies governing restraint use. This was especially troublesome in the area of chemical restraint and nursing responsibilities. For the fourth consecutive reporting period the Facility reported no use of medical restraint for dental procedures and limited use for medical procedures, although the number of medical restraints for medical procedures had increased. The Facility's Self-Assessment identified, for the most part, 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.

- Positive Practices and Improvements Made
  - The Facility continued to make very little use of restraint.
- Improvements Needed
  - Even though number of restraints was low, 50% of the six crisis intervention restraints were likely inappropriate and without clinical justification. While the Facility is to be commended for its continued limited use of crisis intervention restraint (physical holds), as noted throughout this report chemical restraint for crisis intervention was apparently used without regard to adherence to both State and Facility policy.
  - Proper completion of the Restraint Checklist and related documents for both crisis intervention and medical restraint use was problematic.
  - Direct care staff knowledge of basic restraint policy declined appreciably from that observed at the last review. Not all staff had completed required training with the preceding 12 months.

Abuse, Neglect and Incident Management

In its last review, the Monitoring Team found the Facility to be in compliance with 22 out of 22 provisions of Section D. The Monitoring Team noted observable regression during this review. The Facility remained in compliance with all 22 Provisions; however, for three Provisions this finding was conditional in that temporary failure to comply during a period of otherwise sustained compliance does not constitute failure to maintain substantial compliance. This was the case for Provisions D.2.a (late reporting), D.2.c (staff training), and D.3.e (timely initiation and completion of investigations).

- Positive Practices and Improvements Made
    - The Department of Family and Protective Services (DFPS) and Office of the Inspector General (OIG) Investigators interviewed expressed a high level of cooperation between Facility administrative staff and themselves.
    - The internal management and monitoring systems in place at RGSC continued to self-identify most 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. For the most part, these issues were immediately addressed when identified.
    - The Incident Management Review Team (IMRT) process was in place and functioned as a review body, met daily, and its minutes were detailed and reflected review of injuries, incidents, and investigation reports.
    - The Facility's policies and procedures included a commitment that abuse and neglect of individuals would not be tolerated, and required that staff report abuse and/or neglect of individuals. Staff knowledge of these requirements had improved from that noted in the last report by the Monitoring Team.
    - The video surveillance cameras continued to have 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.
- Improvements Needed
    - Not all investigations reviewed by the Monitoring Team were completed within 10 calendar days of the incident or had an approved extension.
    - Not all serious incidents, including allegations of abuse/neglect, were reported to DFPS, or the Facility Director/designee as appropriate, within the required one hour timeframe.
    - Not all staff had completed required training with the preceding 12 months.

<u>Quality Assurance</u>

The Facility had made continued progress in clarifying policy and in implementing procedures designed to improve the Quality Assurance process leading towards substantial compliance with Section E of the Settlement Agreement.

- Positive Practices and Improvements Made
    - The Facility had updated its Quality Assurance policies since the last review. Most significantly the Facility had incorporated multiple Facility-wide QA related policies into one over-arching policy entitled Quality Assurance Plan/Program Narrative – ICF. 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.

- The Settlement Agreement Performance Improvement Council (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." Through this process, data related to all Sections of the SA were regularly reviewed.

- Improvements Needed.
  - 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. The Facility had revised its structure for developing ISPs. QIDP staffing was reorganized to have one QIDP Facilitator and three QIDPs. This had only been in effect for a few months.

- Positive Practices and Improvements Made
  - Attendance of IDT members at annual ISP planning meetings was good for nearly all disciplines.
  - ISPs were revised annually, and ISP meetings for newly admitted individuals were consistently held within 30 days.
- Improvements Needed
  - Timeliness of completing assessments continued to need improvement, although completion of assessments for individuals on admission had improved. Comprehensiveness of assessments varied across disciplines. Use of results from assessments to develop, implement, and revise ISPs was variable; IDTs did not consistently use the available results appropriately to develop, implement, and revise the ISP as necessary.
  - 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.
  - 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 did not describe the methods and strategies, the responsible individuals, or the timelines, and other documents that might have included those were not consistently provided for review.
  - Monthly reviews of progress were not consistently completed each month as required. Reviews of action plans, which were done monthly for each action plan, did not include data and usually did not include an assessment of progress. Overall, reviews did not provide information on progress or regression and served primarily as a reporting and documentation mechanism with little evidence of their use to track progress and plan revisions to supports and interventions.

Integrated Clinical Services

The Facility implemented a policy on Minimum Common Elements of Care that addresses several aspects of clinical care and many of the requirements of Sections G and H. There are many examples of integrated and coordinated clinical services but also examples in which integration needs to be improved.

- Positive Practices and Improvements Made
  - The new policy on Minimum Common Elements of Care provides useful guidance. The Facility may wish to provide additional guidance on what constitutes integrated clinical services to make clear the broad range of opportunities and needs for integrated and collaborative services.
  - The Facility encouraged integrated planning through the ISP process (as reported in Section F), and through several integrated committees and workgroups that addressed both individual care and systemic issues.
  - Facility clinicians documented review of recommendations by consultants and acceptance of consultant reports.
- Improvements Needed
  - The Morning Medical Report meeting, which provides a forum for integrated discussion, communicated information but did not provided meaningful clinical review, did not function in an interdisciplinary manner, and did not demonstrate follow-up to previous reported issues.

Minimum Common Elements of Clinical Care

Progress on this Section was limited since the last compliance visit. The most evident area of progress was in the development of a policy to address the requirements, which now needs to be operationalized and implemented accurately.

- Positive Practices and Improvements Made
  - The Facility had established and implemented a new policy that addressed the requirements of this provision. Improvements Needed
  - Assessments were conducted timely when the IDT identified a change of status for an individual.
- Improvements Needed
  - Overall, improvement is still needed in completing routine assessments. Assessments for the ISP were still not routinely completed on a timely basis. Comprehensiveness of assessments varied across disciplines. Some were generally consistent with requirements, others had most but not all required components, and others continued to miss important components.
  - Timeliness of implementation of treatments and interventions was variable but improving.
  - 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/or systemic review of the common and serious chronic health conditions found in the individuals served at the Facility.

- The Facility had not made progress on establishing a system to monitor the health status of individuals. 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. Although there was some structured use of objective indicators to assess effects of treatments and interventions, this was not consistent across all clinical areas.

At-Risk Individuals

The parties agreed the Monitoring Team would conduct reduced monitoring for Section I of the Settlement Agreement (SA), because the Facility reported it had made limited progress; therefore, the noncompliance findings from the last review would stand. In the previous review, the parties agreed the Monitoring Team would not monitor this Section, because the Facility reported it had made limited to no progress. This continued lack of progress is troubling to the Monitoring Team. From this review the Monitoring Team determined that the Facility continued to have made limited progress in meeting the requirements of this Section.

- Improvements Needed
  - The Facility's management system to identify individuals whose health or well-being is at risk lacked consistency in implementation.
  - ISP meetings did not always adequately address risk related clinical conditions.
  - IHCPs did not always contain necessary information. Implementation was variable.

Psychiatric Care and Services

The Facility made some improvements in the area of psychiatric services, including the development of a new consent form and process for psychotropic medications, and a new process that ensures collaboration between the psychiatrist and neurologist when prescribing psychotropic medications to individuals with comorbid psychiatric and seizure disorders.

- Positive Practices and Improvements Made
  - The Facility ensured psychotropic medications were not used as a substitute for a treatment program, or for staff convenience, and for the documents reviewed, continued to incorporate appropriate DSM diagnosis for conditions that were treated by psychopharmacology.
  - The Reiss Screen was completed as clinically necessary.
  - Psychiatric assessments were comprehensive, and included data and data analysis for targeted behaviors.
  - The comprehensive structural and functional behavior assessment and positive behavior support plans reviewed were incorporated into the psychiatric assessment; and these plans are integrated in the IDT and ISP process.
- Improvements Needed
  - There is a need to develop a process to ensure appropriate usage of pre-treatment sedation.

- Although psychiatric assessments were comprehensive and relied on data, the data were not consistently current. The assessments must rely on more current behavioral data in order to ensure accurate assessment that can lead to appropriate decisions on treatment.
- The IDT did not review the risks and benefits associated with prescribing new psychotropic medications.
- Although the polypharmacy work group provided clinically appropriate reviews of psychotropic polypharmacy, the pharmacist did not actively participate at most meetings.
- The Facility only recently had begun more frequent assessments to monitor for dyskinesia following a change in neuroleptic dosing. The new electronic assessment forms were noted to be disorganized, and not effective for efficacious review of medication side effects. The prescriber did not complete the MOSES and DISCUS assessments, as required for each assessment tool.
- There was a clinically appropriate collaborative effort between the treating neurologist and psychiatrist; however, there was no evidence documenting that recommendations and follow-up plans were incorporating into the individual's psychiatric treatment plan, and no evidence that the information was reviewed by the IDT.

<u>Psychological services</u>

The process of completing the assessment of Section K was complicated substantially by the difficulty in obtaining the documents essential to the review process. Despite repeated requests not all requested materials were submitted. The documents that were submitted to the Monitoring Team suggested that in many cases the Facility had maintained progress toward substantial compliance with the Settlement Agreement. However, there were enough documents not received that the Monitoring Team could not make determinations on compliance with several requirements.

- Positive Practices and Improvements Made
  - The Facility had an adequate number of Board Certified Behavior Analysts (BCBAs), who developed all positive behavior support plans (PBSPs).
  - BCBAs reviewed graphed data monthly. Every progress note reviewed also 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 question.
- Improvements Needed
  - The Peer Review Committee did not have documentation of regular meetings. Meetings with the internal peer reviewer were reported to occur frequently, but no minutes were kept. Peer Review Evaluation Tools were kept.
  - A significant number of PBSPs had not been updated in over a year.
  - Psychological evaluation reports and structural and functional assessments (SFAs) were not consistently completed annually.
  - Not all PBSPs needing consent had current consents in place.
  - PBSPs were not consistently implemented within 14 days following consent.

- There was no evidence the Facility assesses either interobserver reliability or treatment integrity.

Medical Care

There were several areas of improvement in medical care, but there were also areas in which no improvement had occurred. The Facility has had difficulty in retaining primary care physicians, which makes continuing improvement difficult. The Facility had one full-time staff and one contract physician; the contract physician was in process of being employed as staff. The Monitoring Team concurs with the Facility's determination of noncompliance with Sections L.1 through L.4.

- Positive Practices and Improvements Made
  - The Facility had significantly improved the medical management of acute medical conditions.
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- Improvements Needed
  - Although, in general, acute medical issues were initially triaged by the medical provider, there was no evidence of consistent follow-up by the medical provider through full resolution of the acute condition.

Nursing Care

Since the last compliance review, there was no appreciable improvement found in any of the Provisions. However, the recently hired Chief Nurse Executive was in the process of restructuring and reorganizing the Nursing Department. The Nursing Department was fully staffed a with newly hired Chief Nurse Executive and Nursing Operations Officer, along with Unit Nurse Manager, Nurse Educator and four RN Case Managers; with these staff, the Nursing Department should have adequate administrative and management staff. It is expected with these changes and with the full support of the Facility's Administration, if given the authority, the Chief Nurse Executive will be able to improve nursing services and move the Nursing Department forward toward meeting substantial compliance with these Provisions.

- Positive Practices and Improvements Made
  - The Nurse Educator continued to maintain a centralized Nurse Education and Training Database. The Nurse Educator continued to use the state competency-based Nursing Education Hand Book for New Nurse Orientation and annual competencies refresher training.
  - The Facility maintained several positive infection control practices, including ensuring a high percentage of individuals served and employees received vaccinations, handwashing monitoring was completed, and infections and Acute Care Plans (ACPs) for infections were monitored.
  - The Facility continued medication cart exchanges in the Pharmacy. Each nurse was paired with a pharmacy technician to conduct the cart exchange. This improved the efficiency and accuracy of the exchange, enhanced the ability to reconcile medications, and reduced distractions. The nurses observed continued to administer medications and enteral nourishment according to generally accepted standards for safe administration.

- Improvements Needed
    - IRRF and IHCP processes were evolving. As more training is provided and IDT members gain experience 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. IDTs and respective disciplines did not fully consider the interrelationship of risk factors within a category and between categories when determining risk ratings.
    - ACPs continued to need improvement. Monitoring of infections and related acute care plans found significant needs for improvement. As was found at the last compliance review, there was documentation that the Infection Control Preventionist reported the above data to nursing administration, pointing out the deficiencies and recommendations for corrective action. 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, therapeutic response to antibiotic therapy through to resolution, and the implementation of ACPs.
    - There had been no improvement in presence of required content in nursing assessments.
    - Although nursing staff was observed carrying with them a set of Protocol Cards, record review found lack of adherence to following relevant Nursing Protocols.
    - Medication Variance data for the ICF/IID portion of the Facility were not separated from the data from the mental health facility and outpatient clinic. This made it difficult to assess the frequency of medication variances. The Medication Management Workgroup Committee and Pharmacy and Therapeutics Committee need to conduct a more in-depth review of medication variances to ensure that local as well as systemic corrective actions are taken to mitigate medication variances and to evaluate the effectiveness of the corrective actions taken.

<u>Pharmacy Services and Safe Medication Practices</u>

The Monitoring Team recognizes that the Facility had recently hired a new pharmacy director to help develop systems that will better lead the Facility to substantial compliance with Provision N. For this compliance report, the Monitoring Team was concerned that many process that were noted effective during the last compliance review, were no longer effective. In some cases, documents requested by the Monitoring Team were not provided for review. For example, in response to a request for Quarterly Drug Regimen Reviews (QDRRs) completed during the review period, many of the QDRRs that were provided were dated prior to this review period, which in turn indicated that QDRRs were not current. In general, the Facility had not enhanced its pharmacy system, to better ensure the safe provision of pharmacotherapy at the Facility; as required by the Settlement Agreement.

- Positive Practices and Improvements Made
    - The Facility continued to provide a good psychotropic polypharmacy work group meeting that reviewed system issues and provided meaningful clinical reviews of individuals who are proscribed psychotropic polypharmacy.

- Improvements Needed
    - There were examples of QDRRs not being completed quarterly as required, and there were examples of no QDRR being completed for some individuals within this review period. Furthermore, the assessment of metabolic syndrome, of use of benzodiazepines, of polypharmacy, and of overall efficacy and appropriateness of medication usage was not fully addressed within the context of the QDRRs.
    - The pharmacy department had not consistently participated in the psychotropic polypharmacy work group.
    - The Pharmacy Department did not provide comprehensive assessment of the usage of stat chemical restraint, benzodiazepine, and anticholinergic usage.
    - The Facility only recently had begun more frequent assessments to monitor for dyskinesia following a change in neuroleptic dosing; the new electronic assessment forms were disorganized, and not effective for efficacious review of medication side effects. The prescriber did not complete the MOSES and DISCUS assessments as required by each assessment tool.
    - The Facility had not substantially completed training of all relevant staff on the reporting of adverse drug reactions (ADRs), and did not have a process to review ADRs at a systems level.
    - The Facility did not provide documentation indicating the development of drug utilization evaluations (DUEs) for relevant FDA advisories. There was no evidence indicating the development of action plans for identified areas of concerns generated through the DUE process.
    - The Facility had recently developed a new process for addressing medication variances; this process needs to be implemented. The Facility did not demonstrate an effective review of medication variances, and there were no specific action plans developed to address systems issues specific to medication variances.

<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. Another improvement noted was sharing of information between the PNMT and the IDT.

Concerns continued regarding the lack of implementation of plans of care as well as how well the PNMT assessment comprehensively reviewed and provided root analysis of PNM issues.

- Positive Practices and Improvements Made
    - The PNM policy had been revised and represented all components. PNMT members attended the meetings regularly and received sufficient education to assist in performing the job duties.
    - PNMPs were much improved and were contained the areas needed to address PNM issues. PNMPs were updated in a timely manner and were consistent with other plans of care (i.e., IRRFs).

- All staff, new and existing, received both foundational as well as individual-specific training. Greater than 90% of staff had received all necessary training provided through new employee orientation as well as annual refresher courses.
- Return to oral intake was included as part of the Habilitation Assessment and there was a clear determination of whether the individual was a candidate for an oral motor treatment program to improve potential for by mouth (PO) intake.

- Improvements Needed
  - 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.
  - Staff was observed not consistently implementing PNMPs and displaying safe practices that minimize the risk of PNM decline. Individuals were not consistently provided with safe dining strategies.
  - Individual specific training was not provided in a timely manner.
  - The QIDP monthly reviews if completed only stated if changes were made to the PNMP and provided no information regarding status of the individual or if the individual had any issues related to PNM.

<u>Physical and Occupational Therapy</u>

RGSC showed general improvement as it relates to Provision P, although no areas of compliance were noted. The lack of root cause analysis as well as comparative analysis continued to pose concerns with regards to the overall assessment process. Improvement was noted with the monitoring process as it related to frequency of monitors completed, but it still lacked in its ability to monitor all areas that were likely to provoke swallowing difficulties.

- Positive Practices and Improvements Made
  - Assessments were completed in accordance to the schedule set forth by RGSC.
- Improvements Needed
  - Assessments lacked evidence of consistent comparative analysis and measurements to assist in determining the efficacy of the provided interventions.
  - Therapy services were not consistently integrated into the ISP.
  - Progress notes were not comprehensive and did not provide a clear pathway to treatment expectations.
  - There was evidence of NEO training and annual refreshers but inconsistency regarding individualized training.
  - While the monitoring system showed signs of improvement, all areas and times in which swallowing problems were likely to be provoked were not consistently provided. Another concern was that the Facility did not consistently use the data to pinpoint areas of concern on a systemic basis; therefore, the need for training or development of an action plan would be difficult to determine.

Dental Services

There had been no significant improvement with moving towards substantial compliance. To address dental care, the Facility had recently hired a full-time dental hygienist.

- Improvements Needed
  - The Facility did not have a systematic mechanism in place to ensure the appropriate provision of emergency and routine dental services or processes to ensure appropriate oral hygiene and suction toothbrushing.
  - The Facility must develop a program to reduce the need for dental pre-treatment sedation, such as one 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.
  - The Facility should develop a dental QA process that assesses 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.

Communication

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.

- Positive Practices and Improvements Made
  - An increase in communication skill programs was felt to be reflective of the increased ability to perform the tasks needed now that full staffing had been achieved. Staff reported that time has allowed staff the opportunity to implement many processes that now allows for them to meet the needs of the individuals.
  - RGSC did have a comprehensive communication procedure/policy that addressed all components of a functioning system.
  - Speech Therapists had implemented a system by which 10 individuals were being monitored monthly for effectiveness and compliance. In addition, all the communication related skill acquisition plans (SAPs) were reviewed by the SLP.
- 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. It should be noted that timeliness had shown great improvement post December 2014, which coincides with the date that RGSC returned to full staffing.
  - Assessments showed great improvement in identifying opportunities for individuals to utilize the general area augmentative and alternative communication (AAC) devices; improvement is needed in implementing plans for those opportunities and in integrating communication into skill acquisition plans.

- AAC devices were not consistently utilized by individuals.
- Direct support professionals (DSPs) interviewed were not consistently knowledgeable of the communication programs.
- Speech Therapists were actively and consistently monitoring individuals with AAC as well as the general area devices but the results of the monitoring were not well represented as part of the ISPA or QIDP monthly notes.

Habilitation, Training, Education, and Skill Acquisition Programs

The process of completing the assessment of Section S was complicated substantially by the difficulty in obtaining the documents essential to the review process. Despite repeated requests, not all requested materials were submitted. As a result, no skill acquisition plans and only limited numbers of assessment reports were available for review.

- Positive Practices and Improvements Made
  - Functional engagement had continued to increase.
- Improvements Needed
  - Problems were noted in the provision of skill acquisition plans to be implemented in the community.
  - Data collection for skill acquisition plans at the Facility was infrequently conducted, and when conducted was often recorded incorrectly.

Most Integrated Setting

The Facility continues to assist individuals to move to more integrated settings, although the pace has slowed somewhat. It remains less clear that progress is being made toward identifying the supports and protections individuals would need to transition successfully and to making those clear in transition planning.

- Positive Practices and Improvements Made
  - Observation of a post-move monitoring visit indicated a compliant process.

- Improvements Needed
  - RGSC needed to improve its processes to adequately assess, plan for, and implement a plan for each person's needs for education and awareness about community living options. The Monitoring Team encourages the Facility to continue to work toward development of an individualized education/awareness strategy for each individual that takes into account his or her specific learning needs.
  - CLDPs did not adequately reflect the protections, services and supports an individual would need to make a successful transition to community living.
  - Determination by IDT clinicians and the IDT as a whole of appropriateness of referral for transition to a more integrated setting needs to improve.

- Documentation of post-move monitoring findings needs to be more thorough to verify what is observed and what follow-up actions will be taken.

Consent

RGSC continued to make significant efforts to meet all requirements of this provision, including drafting a process for assessing capacity of individuals to make decisions, considering advocates as an alternative to guardianship, and finding means to assist with the financial burden of applying for guardianship. Achieving compliance is dependent on implementation and effective, individualized use of a capacity assessment process and on effect of process to obtain guardians and advocates.

- Positive Practices and Improvements Made
  - The Facility had been making efforts for over six months to develop a tool and process for assessing capacity to make decisions and integrating that into both the determination of need for guardianship or advocate and the rights assessment. The Facility presented an action plan to begin implementation of this process.
  - The Facility maintained a prioritized list of individuals who did not have a current guardianship and were in need of a guardian or advocate; this was updated semiannually.
  - The Facility had taken significant actions to obtain guardians. Actions included establishing a relationship with Texas Rio Grande Legal Aide to assist potential legally authorized representatives (LARs) to apply for guardianship and providing advocacy training for families of individuals.
  - RGSC had continued the remarkable participation of a high percentage of individuals in the self-advocacy meetings; policy was revised to continue the evolution from a staff-directed process to one led by participants with assistance. The Facility reported continuation of the collaboration for self-advocacy training with the Arc of Texas and a private community agency.
- Improvements Needed
  - Observations made by the Monitoring Team of the ISP meetings held during the site visit indicated that IDTs did not undertake any substantive discussion regarding decision-making capacity or strategies to enhance participation in decision-making as they pertained to the ability to provide informed consent.
  - There remained a need to obtain more guardians and advocates, with an expanded focus on recruiting new LARs and advocates in addition to renewing guardianships as they expire.

Recordkeeping and General Plan Implementation

The process for filing and purging in the record differs at RGSC from other facilities in that staff of the Health Information Management (HIM) Department do all filing and purging. Improvements continued to be made in the records, both in terms of presence of documents and meeting Appendix D requirements. A vacancy in the Unified Records Coordinator position caused a lapse in auditing to determine whether records were used in decision-making; that position has been filled.

- Positive Practices and Improvements Made
    - The Facility continues to maintain a Unified Record that includes all required components and in which documents can usually be found. Records comply with most requirements of Appendix D. Active Records and Individual Notebooks were both secure and accessible to staff.
    - 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.
    - The process for tracking deficiencies identified during audits had improved; deficiencies that remained open were noted and highlighted, making it easy to track what needed continuing follow up. Correction of deficiencies had improved significantly since the last report.
- Improvements Needed
    - 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.
    - Problems were found in timely documentation of data, including Aspiration Trigger Sheets and skill acquisition plan (SAP) data.
    - Auditing of meetings and surveying IDT members to assess use of information from the Unified Record had not been done due to vacancy in the URC position.

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.

Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Self-Assessment 5/7/14 2. RGSC Action Plan 5/7/14 3. RGSC Section C Presentation Book 4. DADS Policy 001.1 Use of Restraint (5/22/13) 5. DADS Policy 001.2 Use of Restraint (4/4/14) 6. RGSC SOP ICF-IID 700-14 The Use of Restraint (6/12) 7. RGSC SOP ICR-IID 100-16 Morning Medical Report 8. RGSC SOP NR400-20 The Use of Restraint (5/13) Note: it was reported this SOP was either no longer in use or undergoing substantial revision. Nevertheless it remained listed in the Facility's official listing of policies and procedures 9. RGSC SOP NR400-25 Pre-Treatment and Post Sedation Monitoring (5/13) Note: it was reported this SOP was either no longer in use or undergoing substantial revision. Nevertheless it remained listed in the Facility's official listing of policies and procedures 10. RGSC SOP NR400-33 Supportive/Protective/Adaptive Devices (5/13) Note: it was reported this SOP was either no longer in use or undergoing substantial revision. Nevertheless it remained listed in the Facility's official listing of policies and procedures 11. RGSC SOP ICF-IID 200-02 Restrictive Practices (3/14) 12. RGSC SOP ICE-IDD 300-01 Psychological and Behavioral Services (7/12) 13. RGSC SOP ICF-IID 400-16 Premedication for Medical and Dental Procedures (3/14) 14. RGSC SOP ICF-IID 500-07 Use of Mechanical Devices to Prevent Involuntary Self Injury and to Provide Postural Support (2/14) 15. Crisis Intervention Restraint Log 11/22/13 through 4/30/13 16. Medical Restraint Log 11/22/13 through 4/30/13 17. Restraint Trend Report 4/30/14 18. Settlement Agreement Program Improvement Council (SA-PIC) minutes (11/13 through 4/14) 19. Training records for restraint monitors relative to Sample C.1 20. Sample C.1 Crisis Intervention Restraints (physical) - this was a 100% sample that included all six restraints that occurred since the last review (Individuals #28 (2x), #8, #77, #62 and #139). Five of these six restraints were chemical restraint and none occurred off campus. 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 21. Sample C.2 Staff Training Records for a selected sample of 22 staff which included staff who applied restraint and staff who were named as alleged perpetrators in abuse/neglect allegations

	22. Sample C.3 Medical Restraints - this was a sample of five of 16 medical restraints that occurred since the last review. This represents a 31% sample that included restraint of Individuals # 118, ##51, #8, #15, and #3. 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 23. Sample C.4 Use of Abdominal Binders – this was a 100% sample of the three Individuals reported to use abdominal binders. These were Individuals #146, #79, and #19. Each Individuals Individual Support Plan (ISP), Individual Support Plan Addendums (ISPAs), Integrated Risk Rating Form (IRRF), and medical orders were reviewed **People Interviewed:** 1. Rueben Nieto, BCBA, Psychology Manager 2. Berenice Martinez, BCBA 3. Mary Ramos, QA Director 4. Frank Robles, Security Camera Monitor 5. Victor Ramirez, Security Camera Monitor 6. Robert Prado, MD 7. John Ferris, MD 8. Maia Baker, Chief Nurse Executive (CNE) 9. Emilia Cantu, Rehab Therapy Tech 10. Guadalupe Atkinson, Psychiatric Nursing Assistant I (PNA) 11. Elizabeth Balli, PNA II 12. Vanessa Alvarez, Human Rights Officer 13. Juan Miguel Gonzalez, Program Improvement Manager 14. Lorraine Hinrichs, ICF-IID Program Director 15. Sandra Canales, Settlement Agreement Coordinator 16. Twelve Direct Support Professionals **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 5/22/14 2. Settlement Agreement Performance Improvement Council (SA-PIC) 5/20/14
	Facility Self-Assessment: The Facility provided the Monitoring Team with an excellent self-assessment For Section C that identified, for the most part, the identical issues found by the Monitoring Team. 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: 1. Used formal monitoring/auditing tools. The Facility experienced a small number of restraints since the last review and conducted a review of documentation associated with four of six (67%) restraints. Data resulting from these reviews 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 reviews were completed by the Psychology Manager and used a monitoring tool developed specifically for this purpose. These reviews did not include an inter-rater reliability component.

2. The Facility presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment:
    a. Presented findings based on specific, measurable indicators.
    b. Measured the quality as well as presence of items.
3. The Facility rated itself as being in compliance with only Provision C.2 of Section C. This was not consistent with the Monitoring Team's findings. The Monitoring Team determined the Facility had not achieved substantial compliance with any Provision in Section C of the SA.

The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance.

4. 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 continuation of action steps previously initiated. In fact, this Action Plan included only one newly initiated action step which addressed treatment integrity audits.
5. The Action Plan did not include actions initiated by the Facility to address medical restraint issues such as protocol cards presented at the review entrance meeting.
6. The action steps which have been in place for some time now (many go back to 2012) do not appear to be producing the expected outcomes and leading to SA compliance.

No Provisions in Section C were determined to be in compliance by the Monitoring Team. The Facility will need to examine its Action Plan and make appropriate modifications. Action Steps appeared to be relevant to achieving compliance, but did not contain sufficient specificity. The Facility should also define the provision-specific outcome and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.

For the most part, the Monitoring Team did not identify significant issues that the self-assessment process did not already discover and report. An example of an issue that was not presented in the self-assessment was the lack of training of Restraint Monitors.

Summary of Monitor's Assessment:

Restraint use at the Facility occurred infrequently. This review included a 100% sample of crisis intervention restraint. This included one physical hold and five chemical restraints. During this review the Monitoring Team observed noticeable regression in compliance with long standing policies governing restraint use. This was especially troublesome in the area of chemical restraint and nursing responsibilities.

Post restraint review by the Facility and Monitoring Team review of records determined that 50% of the six crisis intervention restraints were likely inappropriate and without clinical justification, even though

	number of restraints was low. Proper completion of the Restraint Checklist and related documents for both crisis intervention and medical restraint use was problematic. Restraint review conducted by the Psychology Department identified instances where restraint was used inappropriately and without clinical justification. This was a continuation of a deficient practice noted in the last report by the Monitoring Team. While the Facility is to be commended for its continued limited use of crisis intervention restraint (physical holds), as noted throughout this report chemical restraint for crisis intervention was apparently used without regard to adherence to both State and Facility policy. In its last report the Monitoring Team noted that the accuracy and completeness of restraint related documentation, including that completed by nursing staff, had improved from that observed at the last review. Continued improvement was not observed during this review. Direct care staff knowledge of basic restraint policy declined appreciably from that observed at the last review. Not all staff had completed required training with the preceding 12 months. For the fourth consecutive reporting period the Facility reported no use of medical restraint for dental procedures and limited use for medical procedures, although the number of medical restraints for medical procedures had increased. The Facility provided the Monitoring Team with an excellent self-assessment that identified, for the most part, 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	In its last two reports the Monitoring Team noted that the Facility had two separate and distinct policies/protocols 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. Additionally as noted in Facility review of restraint episodes (Provisions C.5 and C.8) certain actions by nurses and physicians (use of medication as restraint) were incorrectly not viewed as restraint at the time of medication administration or were correctly viewed as not being restraint but staff chose to use restraint forms to document the medication administration. In any event, administration of these medications were included in the list of chemical restraints for crisis intervention presented in the document request to the Monitoring Team. The Facility reported that the nursing policy was not in effect for the ICF-IID portion of the Facility,	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>but it was unclear that staff were aware of that, and implementation was not consistent with the ICF-IID policy.

The Monitoring Team had suggested in its last two reports 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. The Facility Psychology Manager reported this review had not occurred and as far as he knew the nursing services manual continued to describe restraint expectations for nursing staff During this review the Facility Psychology Manager reported the Facility was waiting to initiate this review until the latest DADS restraint policy was issued and staff received training from DADS. In subsequent conversation with the Monitoring Team, both the Facility Director and QA Director reported this policy in the nursing manual was not in use as the Facility's new Chief Nurse Executive intended to do a major revision of the manual. This was expected to occur over the next two months. Some of the problems associated with nursing follow-up and chemical restraint use reported in this Section of the SA might be attributable to lack of, or inconsistent, policy direction.

Data provided by the Facility for the past two six month periods, showed:

<table>
<tr><th>Type of Restraint</th><th>5/1/13 to 10/31/13</th><th>11/1/13 to 4/30/14</th></tr>
<tr><td>Crisis Intervention (physical holds)</td><td>6</td><td>2</td></tr>
<tr><td>Crisis Intervention (chemical restraint)</td><td>0</td><td>6</td></tr>
<tr><td>Crisis Intervention (mechanical restraint)</td><td>0</td><td>0</td></tr>
<tr><td>TOTAL Crisis Intervention Restraints</td><td>6</td><td>8</td></tr>
<tr><td>TOTAL Individuals represented in above total</td><td>4</td><td>6</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>0</td><td>0</td></tr>
<tr><td>Medical restraints/dental

Medical restraints/medical procedures</td><td>0

8</td><td>0

18</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>5</td><td>10</td></tr>
</table></td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		While the Facility is to be commended for its continued limited use of crisis intervention restraint (physical holds), as noted throughout this report chemical restraint for crisis intervention was apparently used without regard to adherence to both State and Facility policy. <u>Prone Restraint</u> Based on Facility policy review, prone restraint was prohibited. 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 five individuals, none (0%) showed use of prone restraint. Based on questions posed to 12 direct support professionals, 11 (92%) were aware of the prohibition on prone restraint. This compares to the 100% noted in the last review. 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. These audits, for the most part, showed compliance rates of 100%. <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). The Facility had three Individuals using abdominal binders associated with support for G/J tubes. The Monitoring Team reviewed records for these three Individuals. In each case they included documentation that the use of the abdominal binder was not related to the Individual's behavior and therefore did not represent restraint. The Monitoring Team interviewed direct care staff who regularly work with each Individual. For two of three Individuals (67%) staff described the abdominal binder as necessary because without it the Individual "will pull it (the G/J tube) out – he's done it" and the Individual will "actively try and remove it (the G/J tube)	

#	Provision	Assessment of Status	Compliance
		– really actively." This suggests the purpose of the abdominal binder was to involuntary restrict behavior, i.e. a restraint. The Individual's IDT, in concert with the Facility Psychology Manager, should review the circumstances associated with each of these Individuals to determine if they represent use of physical mechanical restraint for self-injurious behavior (PMR-SIB) according to the definitions in Settlement Agreement and DADS policy, and if so implement procedures to comply with policy provisions governing PMR-SIB. This will be reviewed at the next compliance visit. The Monitoring Team interviewed two Security Camera Monitors to confirm their training in PMAB techniques and restraint use and their acknowledgement that identifying and reporting questionable interactions between staff and Individuals as possible restraint was within their scope of responsibilities. This was the case with both, one of whom worked the day shift and one of whom worked the night shift. Restraint records were reviewed for Sample C.1 that included the restraint checklists, face-to-face assessment forms, debriefing forms, and restraint review documents. The following are the results of this review: 1. In three of the six records (50%), there was documentation showing that the individual posed an immediate and serious threat to self or others. Those that did not included Individual #62 (given a chemical restraint because the "client acting anxious, not following instructions"), Individual #28 (given a chemical restraint because "Individual asked for Ativan and doctor gave it to him"), and Individual #8 (given a chemical restraint but according to the restraint review by the BCBA and HRC "least restrictive methods were not attempted and the client was not in imminent danger to herself or others"). 2. For the six restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that one (17%) contained appropriate documentation that indicated that restraint was not being used for the convenience of staff, or in the absence of or as an alternative to treatment. This was the case with physical restraint of Individual #28. In addition to the three restraints discussed in the previous paragraph there was no documentation provided to the Monitoring Team that measures called for in an Individuals Positive Behavior Support Plan (PBSP) were attempted prior to the use of chemical restraint. This was the case for Individuals #77 and #139. In the case of Individual #77 post restraint review conducted by the Facility determined chemical restraint became necessary because a "pulled staff" from another home was assigned to 1:1 responsibility for Individual #77 and that staff had not been trained in his PBSP. In the case of Individual #139 the physician determined chemical restraint was necessary to prevent self-injurious behavior after the Individual reopened a wound. In this case the Facility BCBA was at the scene of the behavioral event and concurred that chemical restraint was necessary but the Facility form used to document this decision-making was not	

#	Provision	Assessment of Status	Compliance
		completed. No documentation was provided to the Monitoring Team in either case that a psychologist was consulted, as required by policy, prior to the order for chemical restraint to discuss alternatives to the use of chemical restraint and that this consultation was properly documented. As noted above, in one case the Facility BCBA was present and concurred that chemical restraint was necessary. The Chemical Restraint Consult Form was not completed in all five (0%) instances of use of chemical restraint for crisis intervention. This is the form required by policy to document this requirement for the use of crisis intervention chemical restraint. The required post chemical restraint review by a psychiatrist and a pharmacist was not provided for any of the five chemical restraints (0%). 3. In one of the records (17%), 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 the case for physical restraint of Individual #28. For a description of deficient practices refer to the above paragraphs. 4. Facility policies do identify a list of approved restraints. 5. Based on the review of six restraints, involving five individuals, six (100%) were approved restraints although as described above in most instances they were not administered according to policy requirements. 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 parties had agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews: however, in the review of the one physical hold restraint applicable to this Provision the Monitoring Team noted that termination of restraint did not occur as soon as the Individual was no longer a danger to him/herself or others. This was the case with restraint of Individual #28. The Restraint Checklist reports restraint was terminated because the restraint application (horizontal side-lying) had reached the maximum allowable time limit of 15 minutes. The Face to Face Assessment and Debriefing form (FFAD) documents that the Individual "didn't resist during restraint, just being verbally abusive" suggesting that the Individual likely did not need to be restrained for 15 minutes. In its last review the Monitoring Team noted that only 33% of restraints were in compliance with this Provision but because temporary failure to comply during a period of otherwise sustained compliance, does not constitute failure to maintain substantial compliance the Provision remained in compliance. In its last report the Monitoring Team noted that these issues must be addressed to maintain continued compliance. They were not. As a result this Provision is no longer in substantial compliance.	Noncompliance
C3	Commencing within six months of	The Facility's policies related to restraint are discussed above with regard to Section C.1	Noncompliance

#	Provision	Assessment of Status	Compliance
	the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	of the Settlement Agreement. Review of the Facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. Sample C.2 was selected from a current list of staff. A description of Sample C.2 is provided in the Documents Reviewed section above. Facility staff training requirements associated with restraint was deficient. A review of the training transcripts for these staff showed that: 1. Seventeen of 22 (77%) had current training in RES0105 Restraint Prevention and Rules. 2. Nineteen of 22 (86%) had completed PMAB training within the past 12 months. Additionally, 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 Monitoring Team and the Facility and included both am and pm staff. The staff selected were primarily staff who had been involved in restraint application and/or were named as alleged perpetrators in DFPS investigations. Each response was evaluated by one member of the Monitoring Team, the Facility's Program Improvement Manager, and the Facility's Human Rights Officer. Consequently, for each question, responses were subjected to 36 evaluations (twelve Individuals times three raters). The questions used in assessing staff knowledge were identical to the questions used by the Facility in the monthly competency audits conducted by the Facility Human Rights Officer. Based on responses to questions, 12 direct support professionals provided satisfactory responses to the following questions as follows: • "Policies governing the use of restraint require that restraint should only be used if the Individual poses an _____and only after_____." Twenty-five of 36 responses were evaluated as satisfactory (69%). This compares to the compliance percentage of 83% reported in the last review. • "Describe an example of a redirection technique." Thirty-one of 36 responses were evaluated as satisfactory (86%). This compares to the compliance percentage of 97% reported in the last review. • "Describe two physical restraint techniques approved for use at the Facility." Twenty-two of 36 responses were evaluated as satisfactory (61%). This compares to the compliance percentage of 100% reported in the last review.	

#	Provision	Assessment of Status	Compliance
		• "What level of supervision is usually required when an Individual is in restraint?" Twenty-five of 36 responses were evaluated as satisfactory (69%). This compares to the compliance percentage of 75% reported in the last review. • "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 100% 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. These audits, for the most part, showed compliance rates of 100%. The Facility should review its competency testing methodology to ensure it achieves accurate results. As reported in Provision C.1 for Sample C.1 for only one of the six restraints (17%), 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. From the above small sample, staff knowledge had decreased from that noted in the last report by the Monitoring Team for four of five (80%) questions. Restraint policies and related training were in place at the Facility but staff could not consistently provide satisfactory responses to questions associated with the most basic elements of restraint policy and practice. 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 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.	Based on a review of six restraint records (Sample C.1), in three (50%) there was evidence that documented that restraint was used as a crisis intervention in that the Individual posed an immediate and serious threat to self or others. As reported in Provision C.1 this was not the case for Individuals #62, #28, and #8. In review of five Positive Behavior Support Plans, in five (100%), there was no evidence that restraint was intended to be used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). In addition, Facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. The Facility reported it used a "Medical Considerations" form to document that no restraint was used that was 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. In reviewing the five forms associated	Noncompliance

#	Provision	Assessment of Status	Compliance
		with the restrained Individuals, none (0%) were properly completed and signed by both the physician and the QIDP. This form, properly completed and signed only by the physician was provided for two of six (33%) of the records. This was the case for Individuals #8 and #77. For the other four there was no documentation of review and signature by the IDT/QIDP. Sample C.3 consisted of five of 16 medical restraints involving five Individuals. All were medical restraint for medical procedures. In reviewing documentation prepared by the Facility the Monitoring Team determined that: 1. These restraints did not have (0% compliance) appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent). 2. There was no documentation (0% compliance) provided to the Monitoring Team that the Facility attempted to develop treatments or strategies to minimize or eliminate the need for restraint. The Facility presented an ISPA template to be used when the IDT was contemplating medical restraint however for Sample C.3 there was no evidence it had been used. 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 medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may	In its last two reviews the Monitoring Team reported that there was not an adequate training curriculum for restraint monitors 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. The Facility did present a training roster showing that on 3/4/14 the Facility Psychology Manager provided training to 10 Restraint Monitors; however, none of the staff listed as the restraint monitor for the restraints in Sample C.1 (a 100% sample) attended this training. RGSC restraint policy requires that restraint monitors complete the following training, and this training was competency-based. 1. Positive Behavior Support 2. PMAB 3. Restraint: Prevention and Rules for Use at SSLCs 4. CPR 5. Rights of Consumers 6. Abuse and Neglect Based on review of training records, for the six staff at the Facility who performed the duties of a restraint monitor for Sample C.1 none (0%) successfully completed the above training which, according to policy, allows them to conduct face-to-face assessment of individuals in crisis intervention restraint. In fact training transcripts showed that four of	Noncompliance

#	Provision	Assessment of Status	Compliance
	order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	the six did not complete any of the required classes, one completed two (Positive Behavior Support and Restraint), and one completed just one (PMAB). Based on a review of six restraint records (Sample C.1), a face-to-face assessment was conducted: • In none (0%) by an adequately trained staff member. • In four instances (67%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Those that did not were restraints of Individual #28 (chemical restraint) and Individual #139. • In all six (100%), the documentation showed that an assessment was completed of the application of the restraint. This was done by psychology staff and documented on the FFAD. • In all six (100%), the documentation showed that an assessment was completed of the consequences of the restraint. This was done by psychology staff and documented on the FFAD. There were no instances where a physician ordered an alternative monitoring schedule for restraint of any of the five Individuals in Sample C.1. Based on a review of six restraint records for restraints that occurred at the Facility (Sample C.1), five restraints were for chemical restraint and one was for physical restraint. Based on a review of six restraints (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 and up to two hours for chemical restraints, in zero of six (0%) of the instance of restraint, as required by DADS Policy Number 001.1 Use of Restraint. Records that did not contain documentation of this included Individuals #28, #8, #77, #62, and #139. • Monitored and documented vital signs in zero of six (0%) restraints. Records that did not contain documentation of this included Individuals #28 (two restraints), #8, #77, #62, and #139. • Monitored and documented mental status in zero of six (0%) restraints. Records that did not contain documentation of this included Individuals #28, #8, #77, #62, and #139. 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. During the compliance review the Monitoring Team reviewed above individuals' Restraint Checklists and discussed them with the Chief Nurse Executive, Nursing Operating Officer, and Unit Nurse Managers. As a follow-up	

#	Provision	Assessment of Status	Compliance
		action during the ICF Monthly Nurses Meeting on 5/21/14, the nurses for all three shifts were competency-based retrained on the Restraint Checklist regarding nursing monitoring responsibilities. None of the six restraints in Sample C.1 occurred off campus. Sample C.3 included five of 16 instances of medical restraint. The Monitoring Team determined through review of documentation that: 1. In two (40%), the physician specified the schedule of monitoring required or specified that a facility policy/protocol regarding this was to be followed. This was not the case for restraint of Individuals #3, #8, and #51. 2. In two (40%), the physician specified the type of monitoring required if it was different than the facility policy/protocol. This was not the case for restraint of Individuals #3, #8, and #51. Consequently, in 40% of the medical restraints, appropriate monitoring was 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	A sample (Sample C.1) of six Restraint Checklists for individuals in non-medical restraint was selected for review. Documentation was provided to substantiate the following compliance rates for each of the required elements: • In six (100%), continuous one-to-one or enhanced supervision as called for by policy was provided; • In six (100%), the date and time restraint was begun; • In six (100%), the location of the restraint; • In one (17%), 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 the case with Individual #28 (physical restraint); • In six (100%), the actions (or inactions) taken by staff prior to the use of restraint to permit adequate review per C.8; • In six (100%), the specific reasons for the use of the restraint; • In six (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; • In six (100%), the names of staff involved in the restraint episode; • In six (100%), the level of supervision provided during the restraint episode; • One of the six restraints was a physical hold lasting 15 minutes. There was no obvious need for staff to provide, during the restraint, opportunities to exercise	Noncompliance

#	Provision	Assessment of Status	Compliance
	Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. • One of the six restraints was a physical hold. In this case, the date and time the individual was released from restraint was properly documented (100%); and • In six (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 six records (Sample C.1), restraint debriefing forms that contained data consistent with that reported on the Restraint Checklist had been completed for three (50%). This was not the case for Individuals #28 (physical restraint), #8, and #139. Injury related entries on the Restraint Checklist and the FFAD did not provide consistent accounts of injury related circumstances. As reported in Provision C.4, for the five Individuals subject to medical restraint (Sample C.3) there was no evidence that the monitoring had been completed as required by the physician's order for three (60%) because the physician order did not specify the schedule and type of monitoring required. Sample C.1 included five crisis intervention chemical restraints. The Monitoring Team reviewed documentation associated with these chemical restraint. In all five cases no documentation (0%) was provided to the Monitoring Team that would validate 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 has been a pervasive problem at the Facility with a similar deficiency reported in the last two reviews. 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	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

#	Provision	Assessment of Status	Compliance
	times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;		Not rated
	(b) review possibly contributing environmental conditions;		Not rated
	(c) review or perform structural assessments of the behavior provoking restraints;		Not rated
	(d) review or perform functional assessments of the behavior provoking restraints;		Not rated
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;		Not rated
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant		Not rated

#	Provision	Assessment of Status	Compliance
	treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and		
	(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.	Documentation related to six 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 where applicable and staff interviews. This documentation showed that: • In none (0%), 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. • In none (0%), 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 six (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 (morning medical meeting) 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 for the most part to only record that the event happened. • In four (67%) the review conducted by 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. This was not the case for restraint of Individuals #8 and	Noncompliance

#	Provision	Assessment of Status	Compliance
		#139. 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 5/7/14 2. RGSC Action Plan 5/7/14 3. RGSC Section D Presentation Book 4. DADS Policy 21.2 Protection From Harm - Abuse, Neglect, and Exploitation 11/5/13 5. DADS Policy 2.5 Incident Management (11/5/13) 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. Witnessed Injury log 11/1/13 to 3/31/14 11. Discovered Injury log 11/1/13 to 3/31/14 12. Unusual Incident and serious injury logs 11/1/13 to 3/31/14 13. DFPS Investigation case log 11/1/13 to 3/31/14 14. OIG Investigation case log 11/1/13 to 3/31/14 15. Incident Management Review Team (IMRT) minutes for meetings associated with investigation Samples D.1 and D.2 16. Self-Advocates meeting minutes 12/17/13, 1/21, 1/27, 2/14, 2/26, 3/20, and 3/26/14 17. Meeting minutes: DFPS/OIG/RGSC Quarterly Coordination meeting held 12/4/13 18. Injury Audit Record Reviews for November, 2013 through April, 2014 19. Secondary Investigation Audits for January, February, and March 2014 *20.* Sample D.1: included a sample of 10 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 10 of the 28 investigations (a 36% 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 43077495, 42994175, 42922013, 43070319, 42980812, 42982109, 42941322, 42982135, 42987773, and 42920805 *21.* 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 15 (a 33% sample) reported facility only investigations. Investigation records included UIRs 14-014, 019, 023, 024, and 028 22. Sample D.3 included 12 Individual Support Plans (ISPs) for Individuals #3, #8, #15, #19, #51, #62, #77, #28, #79, #118, #126, and #139 **People Interviewed:** 1. Myrna Wolfe, Incident Management Coordinator (IMC)

	2. Vanessa Alvarez, Human Rights Officer 3. Juan Miguel Gonzalez, Program Improvement Manager 4. Frank Robles, Security Camera Monitor 5. Victor Ramirez, Security Camera Monitor 6. Mary Ramos, Quality Management Director 7. Sandra Canales, Settlement Agreement Coordinator 8. Michael Rodriguez, APS (DFPS) Investigator 9. Jose Omar Mendiola, APS (DFPS) Facility Supervisor 10. Maria Cavazo, Internal Affairs Investigator (OIG) 11. Robert Esparza, Manager, OIG Internal Affairs Division 12. Laura Coronado, Health Information Management (HIM) Supervisor 13. Twelve Direct Support Professionals **Meetings Attended:** 1. Incident Management Review Team (IMRT) 5/22/14 2. Settlement Agreement Performance Improvement Council (SA-PIC) 5/20/14
	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; however, for three Provisions this finding was conditional in that temporary failure to comply during a period of otherwise sustained compliance does not constitute failure to maintain substantial compliance. This was the case for Provisions D.2.a (late reporting), D.2.c (staff training), and D.3.e (timely initiation and completion of investigations). 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: 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 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. b. These monitoring/audit tools included adequate 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. d. 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. e. The monitoring/audit tools did not have adequate written instructions/guidelines to ensure consistency in monitoring and the validity of the results. f. 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. g. 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). h. 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. 2. The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: a. Presented findings consistently based on specific, measurable indicators and used these data in initiating corrective actions b. Consistently measured the quality as well as presence of items. 3. 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. 1. Actions were reported as continued audit reviews and commensurate corrective action plans. 2. 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. 3. For the most part, the actions provided a set of steps likely to lead to continued compliance with the requirements of this Section. For those Provisions rated in compliance but conditionally by the Monitoring Team the Facility should examine its Action Plan and make appropriate modifications. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcome and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: In its last review the Monitoring Team found the Facility to be in compliance with 22 out of 22 provisions of Section D. The Monitoring Team noted observable regression during this review. The Facility remained in

	compliance with all 22 Provisions; however, for three Provisions this finding was conditional in that temporary failure to comply during a period of otherwise sustained compliance does not constitute failure to maintain substantial compliance. This was the case for Provisions D.2.a (late reporting), D.2.c (staff training), and D.3.e (timely initiation and completion of investigations). Not all investigations reviewed by the Monitoring Team were completed within 10 calendar days of the incident or had an approved extension. Not all serious incidents, including allegations of abuse/neglect, were reported to DFPS, or the Facility Director/designee as appropriate, within the required one hour timeframe. Not all staff had completed required training with the preceding 12 months. The DFPS and OIG Investigators 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 facilitated timely communication between the Facility and DFPS. Both investigators reported concern about feared retaliation expressed by some staff in the course of interviews. OIG reported that four employees interfered with an investigation of physical abuse by coordinating the content of their witness testimony to protect a coworker. This collusion came to light through the course of the investigation resulting in a confirmed finding. The internal management and monitoring systems in place at RGSC continued to self-identify most 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. For the most part, these issues were immediately addressed when identified. The IMRT process was in place and functioned as a review body, met daily, and its minutes were detailed and reflected review of injuries, incidents, and investigation reports. The Facility's policies and procedures included a commitment that abuse and neglect of individuals would not be tolerated, and required that staff report abuse and/or neglect of individuals. Staff knowledge of these requirements had improved from that noted in the last report by the Monitoring Team. Through the course of reviewing investigations, the Monitoring Team noted that the video surveillance cameras continued to have 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. Presentation of information in UIRs continued to be 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 continued to be 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 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.	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	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	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.</td><td>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.

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 last two six-month periods were:

<table>
<tr><th></th><th>5/1/13 to 10/31/13 (previous six months)</th><th>11/1/13 to 4/30/14 (recent six months)</th></tr>
<tr><td>Total physical abuse allegations</td><td>13</td><td>14</td></tr>
<tr><td>Number confirmed</td><td>2</td><td>2</td></tr>
<tr><td>Number inconclusive</td><td>0</td><td>1</td></tr>
<tr><td>Total verbal/emotional abuse allegations</td><td>5</td><td>3</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>
<tr><td>Total neglect allegations</td><td>9</td><td>24</td></tr>
<tr><td>Number confirmed</td><td>2</td><td>2</td></tr>
<tr><td>Number inconclusive</td><td>0</td><td>1</td></tr>
<tr><td>Total exploitation allegations</td><td>0</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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</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		Other Serious Incidents	

	5/1/13 to 10/31/13	11/1/13 to 4/30/14
Deaths	0	0
Serious Injuries	9	9
Sexual Incidents	2	0
Suicide Threat (credible)	1	1
Unauthorized Departure	3	10
Choking	1	2
Other	0	1

In order to evaluate staff knowledge in the area of incident reporting 12 Direct Care Professionals were asked a series of questions. The 12 staff were selected by the Monitoring Team and the Facility and included both am and pm staff. The staff selected were primarily staff who had been involved in restraint application and/or were named as alleged perpetrators in DFPS investigations. Each response was evaluated by one member of the Monitoring Team, the Facility's Program Improvement Manager, and the Facility's Human Rights Officer. Consequently, for each question, responses were subjected to 36 evaluations (twelve staff times three raters). The questions used in assessing staff knowledge were identical to the questions used by the Facility in the monthly competency audits conducted by the Facility Human Rights Officer. Based on responses to questions, 12 direct support professionals provided satisfactory responses to the following questions as follows:

"What is the reporting procedure and timeframe when abuse/neglect is suspected?" 34 of 36 responses were evaluated as satisfactory (94%). This compares to the compliance rate of 50% reported in the last review.

"What is the reporting procedure and timeframe for other serious incidents?" 31 of 36 responses were evaluated as satisfactory (86%). This compares to the compliance rate of 33% reported in the last review.

This improvement is noteworthy. 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 on

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		these competency checks is maintained and a monthly summary is prepared and presented to the QA Director and the SA-PIC. These audits, for the most part, showed compliance rates of 100%. The Facility should review its competency testing methodology to ensure it achieves accurate results. Based on a review of the ten investigation reports included in Sample D.1: Eight (80%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by DADS/Facility policy. This was not the case for investigations 43070319 and 42980812. DFPS case 4307319 was also investigated by OIG (case 13360-14). The OIG investigation reported that a witness to abuse had failed to report the abuse because of fear of retaliation. OIG substantiated criminal activity on the part of this employee and referred the matter to the District Attorney for consideration for prosecution for "failure to report a felony". This employee is no longer employed by the Facility. For case 42980812 the DFPS investigation report notes that an unknown staff member neglected an individual on 12/27/13. This was not reported (presumably anonymously) until 1/3/14. Whoever was aware of, or suspected, this neglect on 12/27/13 should have reported it. The accompanying UIR did not list any future actions directed at staff education regarding reporting responsibilities. In both cases staff who should have reported an allegation did not. Eight (80%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. This was not the case for investigations 43070319 and 42980812. Based on a review of five investigation reports included in Sample D.2: 1. Two (40%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. Those that did not included UIRs 014, 023, and 028. In the case of UIRs 014 and 023 the Facility self-identified the late reporting and took administrative action with the offending employee. In the case of UIR 028 no report occurred until the Facility physician confirmed a serious injury even though the nature of the injury (which required an emergency room [ER] visit) should have been reported earlier. While DADS policy does not technically acknowledge an injury as being "serious" until so labeled by a physician there are instances where the very nature of an injury (such as was the case with bruising and swelling requiring an ER visit) suggests seriousness and should be immediately reported to the Facility Director/designee in order to determine if any client protection measures need to be immediately implemented. 2. Two (40%) included evidence that unusual/serious incidents were reported to the appropriate party (DADS central office) as required by DADS/Facility policy. The Facility did have a standardized reporting format. Based on a review of 15	

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		investigation reports included in Samples D.1 and D.2, 15 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. Additionally, the Monitoring Team interviewed two Security Camera Monitors to confirm their training in abuse/neglect and unusual incidents and their acknowledgement that identifying and reporting questionable interactions between staff and Individuals as possible abuse or neglect was within their scope of responsibilities. This was the case with both, one of whom worked the day shift and one of whom worked the night shift. 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. The Facility had implemented a system whereby the Facility's Human Rights Officer (HRO) reviewed the residential unit's review of non-serious discovered injuries. These are referred to as Secondary Investigation Audits. The unit investigations consisted of a "Discovered Injury Preliminary Investigation" and a "Discovered Injury Secondary Investigation". The HRO reviewed of 20% of non-serious discovered injuries for content and quality. These injuries were randomly selected. This process was used instead of the Non-Serious Injury Investigation process established by DADS and was reportedly accepted by DADS as an acceptable alternative. The Monitoring Team reviewed the three most recent months of Secondary Investigation Audits completed by the HRO and found them very complete and thorough. Of the 15 audits completed during this three month period only one unit investigation was found to be complete and acceptable. Fourteen were returned to the unit for additional investigation and review of the circumstances associated with the discovered non-serious injury. The process for review of discovered non-serious injuries at the RGSC is exemplary and considered best practice. The Facility is to be commended for continuing this as it demonstrates commitment to client protection. Based on this review the Monitoring Team determined this Provision remained in compliance in that temporary failure to comply during a period of otherwise sustained compliance, does not constitute failure to maintain substantial compliance. To remain in compliance reporting timely will need to meet the Monitoring Team's metric benchmark of 90% at the next review.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate	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 affected 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.	Substantial Compliance

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	action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	Based on a review of 10 investigation reports included in Sample D.1, in five cases an alleged perpetrator was named. In five (100%) the alleged perpetrator was removed from direct contact with individuals immediately following the Facility being informed of the allegation. Based on a review of 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. Based on a review of ten investigation files, it was documented that adequate additional action was taken to protect individuals in ten 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 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. Nevertheless, because of issues related to late reporting described in Provision D.2.a the Monitoring Team was concerned with staff knowledge and training and the impact this could have on late reporting and the related delay in necessary client protection measures being put in place and determined that a limited review was in order. This limited review consisted of a review of a sample of staff training transcripts and questioning a sample of staff. Facility staff training requirements associated with abuse/neglect and unusual incidents was deficient. The Monitoring Team reviewed staff development training transcripts related to Sample C.2 (22 employees) which showed that the Facility was not current in abuse/neglect training and in unusual incident training. The training transcripts showed 15 of 22 employees (68%) had completed the Abuse/Neglect (ABU0100) class within the last 12 months and 17 of 22 (77%) had completed the Unusual Incidents (UNU0100) within the last 12 months. Additionally, 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 Monitoring Team and the Facility and included both am and pm staff. The staff selected were primarily staff who had been involved in restraint application and/or were named as alleged perpetrators in DFPS investigations. Each response was evaluated by	Substantial Compliance

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		one member of the Monitoring Team, the Facility's Program Improvement Manager, and the Facility's Human Rights Officer. Consequently, for each question 36 responses were evaluated (twelve staff' times three raters). Based on responses to questions, 12 direct support professionals provided satisfactory responses to the following questions as follows: "Name two signs or symptoms of abuse." 34 of 36 responses were evaluated as satisfactory (94%). This compares to the compliance rate of 100% reported in the last review. "Name two signs or symptoms of neglect." 33 of 36 responses were evaluated as satisfactory (92%). This compares to the compliance rate of 83% reported in the last review. "Name two types of serious/unusual incidents (other than abuse/neglect) that must be reported." 29 of 36 responses were evaluated as satisfactory (81%). This compares to the compliance rate of 89% reported in the last review. The Facility had a process for checking staff competencies. Each month 10 staff, randomly selected, were quizzed by the Human Rights Office (HRO). If on the spot retraining was needed the HRO provided it. Data collected related to these competency checks was maintained and a monthly summary was prepared and presented to the QA Director and the SA-PIC. These audits, for the most part, showed compliance rates of 100%. The Facility should review its competency testing methodology to ensure it achieves accurate results. Based on this review the Facility remained in substantial compliance because temporary failure to comply during a period of otherwise sustained compliance, does not constitute failure to maintain substantial compliance. The issues associated with staff training must be corrected in order to maintain continued 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	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.	Substantial Compliance

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	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.		
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	The 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. While not part of the review it is noteworthy that self-advocate meetings were held at least monthly and were well attended. Abuse and neglect reporting was regularly reviewed as a means of providing ongoing education to individuals.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	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.	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. The substantial compliance finding from the last review stands.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats	The parties agreed the Monitoring Team would conduct reduced monitoring for this subsection, because previous reviews showed substantial compliance. Interviews with Facility administrative staff, outside investigators, and review of investigation reports were used to confirm whether or not the Facility remained in substantial compliance. According to RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation, retaliation against reporters of abuse/neglect is prohibited and not tolerated. Based on interviews with the Facility administrative staff, these requirements	Substantial Compliance

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	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.	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. Facility administrative staff reported there were no reports made to the Facility of actual or perceived retaliation since the last review. Based on a review of investigation records (Sample D.1 and Sample D.2), there was one investigation where concerns were noted related to potential retaliation. DFPS case 4307319 was also investigated by OIG (case 13360-14). The OIG investigation reported that a witness to abuse had failed to report the abuse because of fear of retaliation. OIG substantiated criminal activity on the part of this employee and referred the matter to the District Attorney for consideration for prosecution for "failure to report a felony". This employee is no longer employed by the Facility. 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 that except for the above referenced OIG case there were no instances of perceived or actual retaliation reported. 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). Outside investigators (DFPS and OIG) reported concerns with perceived or actual retaliation in the course of their interviews with witnesses. The Facility needs to be more proactive in educational efforts regarding retaliation, including mechanisms to ensure protection of staff who report allegations. 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 defined sufficient procedures to audit whether significant injuries of a sample of Individuals were reported for investigation. This was conducted by the HIM Department. Since the last review 15 audits had taken place representing 23% of the Facility census. Facility policy also required a trend review of incidents for a sample of Individuals each month. The trend review was conducted by a Facility Investigator. This review examined source documents and was very detailed in 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.	Substantial Compliance

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		Since the last review 17 trend reviews had taken place representing 26% of the Facility census. For both processes, results were presented to the Facility QA Department for inclusion in regular reporting to the Settlement Agreement Program Improvement Council (QAQI Committee). The Monitoring Team determined that the audits conducted were sufficient to determine whether significant resident injuries had been reported for investigation and that the trend review was comprehensive and thorough. 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. 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	The parties agreed the Monitoring Team would not monitor this Provision (except to the extent the Facility had new investigators in which case their training records would be reviewed) because the Facility was in substantial compliance for more than three consecutive reviews. This Provision remained in substantial compliance. The Facility had one new investigator and the Monitoring Team determined that all training requirements had been met.	Substantial Compliance

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	perpetrator.		
	(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. The substantial compliance finding from the last review stands. In the context of review of other Section D Provisions both DFPS and OIG investigators reported a high level of cooperation from Facility staff.	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. The substantial compliance finding from the last review stands.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	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. As noted in its previous reports the Monitoring Team remains concerned that no action had been taken regarding an important provision of State and Facility policy regarding testimonial evidence. According to State and Facility policy, steps are to be taken to preserve physical evidence and should prioritize the collection of evidence that is most at risk of contamination. The State and Facility policy further states that "in most cases the highest priority will be to identify interviewees and physically separate them until they have been interviewed." The Monitoring Team found no evidence that would suggest this component of the Facility and DADS policy (separation of witnesses 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. As a practical matter this would be difficult since DFPS usually does not conduct interviews of collateral witnesses or alleged perpetrators (APs) until days after an allegation is reported. The lack of compliance with this policy has the potential to affect an investigation. For example, in DFPS investigation 43070319 the DFPS investigator specifically expressed concern with respect to pre-interview collusion on the part of alleged perpetrators and collateral witnesses. In this case the alleged abuse/neglect occurred on Sunday 3/23/14. OIG determined it would investigate this allegation and initiated interviews on Friday 3/28/14. Through the course of the investigation OIG determined the alleged perpetrators met on more than one occasion to "get their stories straight". At some point in the OIG investigation process one of the alleged perpetrators felt a need, after initial	Substantial Compliance

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		interviews, to come forward with truthful statements. As reported by OIG to the Monitoring Team, had this not happened it was likely that OIG (and subsequently DFPS) would have returned inconclusive or unsubstantiated findings. Instead abuse was confirmed by DFPS and substantiated criminal activity was found by OIG against two employees. OIG referred both to the District Attorney for consideration of felony prosecution. OIG reported optimism that prosecution would be pursued. The Facility and DADS should review its policy with respect to testimonial evidence. It would be helpful if DADS provided 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**.** The Facility was unaware of any action in this regard.	
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. Because of the small number of investigations at the Facility the sample was already small (10 for DFPS investigations and five for Facility-only investigations). Consequently all were reviewed to assess compliance with this provision. 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 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: • Ten of 10 (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	Substantial Compliance

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		well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. The following are examples of actions from 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 10 (80%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. Those that did not were investigations 43070319 and 42920805. Investigation 4307319 began on 3/24/14 and was completed on 4/4/14 (11 days). No extension request documentation was provided to the Monitoring Team. Investigation 42920805 began on 11/1/13 and was completed on 12/20/13. In this case, there was subsequent review after the investigation was closed. The regional DFPS office began their review on 12/6/2013, and it was completed on 12/20/13. During the review, additional information was obtained. Under DFPS rules, an extension request is not required for a post-investigative review. Nonetheless, such a review should also be completed within an additional 10-day period unless there are extraordinary circumstances. • Ten (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 three of the investigations reviewed, recommendations for corrective action were included. In three 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	

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		basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. • In five (100%) of the investigations reviewed, recommendations for corrective action were included. In four of the investigations (80%), 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. For UIR 014 the investigation identified late reporting but did not address any recommendations to address this. 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 (timely completion or approved extensions) must be corrected in order to maintain continued 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	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 nine out of 10 investigations reviewed (90%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The exception was investigation 42920805 (serious discovered injury – fractured arm). This was reported as an allegation of abuse/neglect on 11/1/13 and initially returned to the Facility by DFPS as an administrative referral on 11/21/13. The Facility did not feel the investigation resulting in the administrative referral was thorough. The Facility asked DFPS to reconsider and fully investigate the allegation, which they did, returning a finding of inconclusive on 12/20/13. This incident was subsequently reviewed by DADS regulatory in January, 2014 with DADS regulatory concluding that the incident	Substantial Compliance

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	previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	was not thoroughly investigated pointing specifically to discrepancies between staff statements and video surveillance. Subsequent to this finding the Facility conducted an additional investigation which examined additional evidence (including additional staff interviews) and reached an inconclusive finding on 3/12/14. The Facility was not able to provide evidence of final review of this investigation by the Facility Review Authority. Consequently, it was unclear if there was agreement on the final inconclusive findings and what follow-up action, if any, was taken. The final result of all this investigatory activity did not validate that the contents of the final Facility investigation report were sufficient to provide a clear basis for its conclusion because there was no evidence that the final investigation report was reviewed and approved by the Facility Review Authority. ▪ The report utilized a standardized format that set forth explicitly and separately: • In 10 (100%), each unusual/serious incident or allegations of wrongdoing; • In 10 (100%), the name(s) of all witnesses; • In 10 (100%), the name(s) of all alleged victims and perpetrators; • In 10 (100%), the names of all persons interviewed during the investigation; • In 10 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; • In 10 (100%), all documents reviewed during the investigation; • In 10 (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; • In 10 (100%), the investigator's findings; and • In 10 (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	

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		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 this Provision remained in substantial compliance.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	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 the requirements of Section D.3.e (excluding timeliness requirements) and D.3.f; • Ten of 10 (100%) were reviewed by the Review Authority, which includes the Incident Management Coordinator and the Facility Director within five working days of receipt of the completed investigation. Note: as reported in Provision D.3.f the Facility was unable to produce documentation that the Facility Review Committee reviewed the final Facility investigation initiated in response to DFPS case 42920805 (serious discovered injury – fractured arm). It had reviewed the DFPS investigation report within required timeframes • 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. <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	Substantial Compliance

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		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. Note: as reported in Provision D.3.f the Facility was unable to produce documentation that the Facility Review Committee reviewed the final Facility investigation initiated in response to DFPS case 42920805 (serious discovered injury – fractured arm). This was UIR 42920805 (apparently the Facility assigns the DFPS case number as the UIR case number under these circumstances). Consequently, five of six (83%) Facility investigations were reviewed according to the requirements of this Provision of the SA, and overall 15 of 16 (94%) were reviewed according to the requirements of this Provision of the SA. 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 recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	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. For investigations reviewed for Samples D.1 and D.2 in which disciplinary action was warranted, prompt and adequate disciplinary action had been taken and documented in each instance. For investigations reviewed for Samples D.1 and D.2 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	Substantial Compliance

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		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. The substantial compliance finding from the last review stands.	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 validate that the systems for the tracking and trending of incidents and investigations, and appropriate administrative follow-up that had been established at the Facility continued to be in place and used effectively. For example, for all categories of unusual incident categories and investigations, the Facility continued to maintain a system that allowed tracking and trending by: o Type of incident; o Staff alleged to have caused the incident; o Individuals directly involved; o Location of incident; o Date and time of incident; o Cause(s) of incident; and o Outcome of investigation. Over the past two quarters, the Facility's trend analyses: o Were conducted at least quarterly; o Did address the minimum data elements; o Did use appropriate trend analysis procedures; o Did provide a narrative description/explanation of the results and conclusions; and o 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	Substantial Compliance

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		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 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	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.	Substantial Compliance

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	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 5/7/14 2. RGSC Action Plan 5/7/14 3. RGSC Section E Presentation Book 4. DADS Policy 3.1 Quality Assurance (5/22/13) 5. RGSC SOP QM 100.011 Quality Assurance Plan/Program Narrative – ICF (4/14) 6. RGSC SOP QM 100.15 DADS Quality Assurance Expectations (4/14) 7. RGSC Quality Assurance Plan 4/14 8. Settlement Agreement Performance Improvement Council (SA-PIC) meeting minutes (including extensive attachments) for 12/13 through 4/14 9. RGSC Monthly Trend Analysis Report 3/31/14 10. RGSC Quarterly Trend Analysis Report 2/28/14 11. Corrective Action Plan (CAP) Report showing all CAPs opened from 11/25/13 to 4/23/14 12. Sample of completed SA monitoring tools 13. Sample of Incident Management Review Team (IMRT) minutes 14. Sample of 11 CAPs 15. CAP initiation audits for February, March, and April 2014 16. CAP completion audits for February, March, and April 2014 17. Open Cap Status Report 5/21/14 18. Summary of CAP effectiveness audits **People Interviewed:** 1. Mary Ramos, Quality Management Director **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 5/22/14 2. Settlement Agreement Performance Improvement Council (SA-PIC) 5/20/14
	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 fully 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 fully established between the various Facility staff responsible for the completion of the tools. h. The Facility did not appear to have a comprehensive monitoring tool to assess its progress towards implementing its QA program and meeting all SA requirements associated with Section E. 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. The Facility reported it had recently hired a new data analyst and expected significant improvement in data preparation and analysis by the next review. 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.3 of Section E. 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. 1. Actions were reported as completed, in process, or not started. 2. The Facility data identified areas of need/improvement. Most action steps were a continuation of previously initiated actions developed to move the Facility closer to compliance, Many had a completion date noted as 6/30/14 The actions did provide a set of steps likely to lead to compliance with the requirements of this Section. For those Provisions determined to be in noncompliance by the Monitoring Team the Facility should examine its Action Plan and make appropriate modifications. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcome and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete

	analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: The Facility had made continued progress in clarifying policy and in implementing procedures designed to improve the Quality Assurance process leading towards substantial compliance with Section E of the Settlement Agreement. The Facility had updated its Quality Assurance policies since the last review. Most significantly the Facility had incorporated multiple Facility-wide QA related policies into one over-arching policy entitled Quality Assurance Plan/Program Narrative – ICF. 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. 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." Through this process, data related to all Sections of the SA were regularly reviewed. In previous 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 although the Facility reported this was expected to improve by the time of the next review. In its last report the Monitoring Team noted that the Facility was able to produce volumes of QA related data but it was often difficult to determine its relevance to a particular SA section, was not always cross-referenced to SA Sections, and was not consistent in the formatting of various reports. Improvements had been made in this regard but the Facility acknowledged more are needed. The Facility collected data that was tracked and trended for every Provision of the Settlement Agreement. The volume of data is cumbersome (96 data reports for the QA Matrix and 292 data reports for the Key Indicator Matrix). The Facility may want to consider reviewing the organization of these data such that those of major importance are in some way highlighted. 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. Every Section of the SA had at least some data reporting in place, especially related to the data requirements associated with the key indicators. Data collection, reporting, and trending for the key indicators developed by the Facility had matured from that observed at the last review. Data collection, reporting, and trending were not consistent in all areas of the ICF-IID program. Trend analysis was evident

	for most sections of the SA, and was generally organized in a way that would be meaningful and understandable to those responsible for oversight (SA-PIC). Nevertheless, at this point the data system developed by the Facility was being used more for management oversight and performance accountability than for performance improvement purposes although the Facility reported this was expected to change by the time of the next review. Corrective Action Plans (CAPs) continued to be singularly focused almost exclusively on employee related performance issues, practices of an IDT related to one Individual, or administrative issues which are more appropriately addressed through the supervisory chain of command. The Facility is to be commended for initiating and continuing to conduct CAP Initiation Audits, CAP Completion Audits, and CAP Effectiveness Audits. These are positive steps that should lead to compliance in future reviews.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	The Facility had made continued progress in clarifying policy and in implementing procedures designed to improve the Quality Assurance process leading towards substantial compliance with Section E of the Settlement Agreement. <u>Facility QA policies and practices</u> The Facility had updated its Quality Assurance policies since the last review. Most significantly the Facility had incorporated multiple Facility-wide QA related policies into one over-arching policy entitled Quality Assurance Plan/Program Narrative – ICF. This was effective in April, 2014. This policy adequately supported the state policy for quality assurance and included: ▪ a description of the purpose of the QA program, ▪ the organizational structure of the QA process (including individual roles and responsibilities), ▪ the data list/inventory, ▪ the QA matrix, ▪ key indicators used at the Facility, ▪ a description of how data are summarized and analyzed, ▪ a description of the role of other clinical and operational departments in QA, ▪ description of workgroups/Performance Improvement Teams, ▪ the QA report, ▪ a description of the SA-PIC and its role in reviewing data and guiding the entire QA process, and ▪ description of the corrective action plan (CAP) process	Noncompliance

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		The Facility also conducted a review of discipline related policies to identify those that contained a QA component governing QA activity for that particular discipline. This review identified 17 such policies including: • Most Integrated Setting • Incident Management • Protection from Harm –ANE • At Risk • Dental Services • Psychiatric Services • Medical Care • Minimum Common Elements • Physical Nutritional Management Team (PNMT) • Occupational/Physical Therapy (OT/PT) • Communication • Individual Support Plan (ISP) • Habilitation, Training, Education, and Skill Acquisition • Restraint • DADS Pharmacy Services • Medication Variance • ICF Monthly Record/Assessment Review The Facility's Settlement Agreement Performance Improvement Council (SA-PIC) performed the same functions as the Quality Assurance/Quality Improvement (QAQI) Council required by State policy. The SA-PIC routinely met twice a month. One meeting was referred to as a "business meeting" and the other meeting was referred to as an "action plan meeting." Detailed agendas and minutes were maintained for both meetings. The Facility reported, and minutes showed, the action plan meetings 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 observed one such meeting during this review and observed active engagement among committee members. The agendas of the "business meeting" included regular review of some sections of the SA, primarily Sections C and D. This meeting also had standing agenda items related to staff training compliance, review and analysis of QA data, review of medical provider audits, and review of Corrective Action Plans (CAPs). In its last report the Monitoring Team noted that the Facility was able to produce volumes of QA related data but it was often difficult to determine its relevance to a particular SA section, was not always cross-referenced to SA Sections, and was not consistent in the formatting of various reports. Improvements had been made in this regard but more are needed. For example, each page of the QA Plan Matrix that reports	

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		on SA Sections repeats column headers on the top making it easy for users, especially "occasional users" to understand the data presented in the 15 columns on each page. This formatting is not used for the 18 page key indicator portion of QA Plan Matrix. The Facility collected data that was tracked and trended for every Provision of the Settlement Agreement. In its last report the Monitoring Team noted that data collection, reporting, trending, and analysis were most complete and comprehensive for various reports associated with Section C (restraints) and Section D (abuse, neglect, exploitation and incident management). This had expanded and at the time of this review data collection, reporting, trending, and analysis was much more comprehensive. For example, at the time of this review every Section of the SA had at least some data report in place, especially related to the data requirements associated with the key indicators. Data collection, reporting, and trending for the key indicators developed by the Facility had matured from that observed at the last review. The Key Indicators matrix presented to the Monitoring Team showed 292 distinct data reports associated with all 19 sections of the SA. The Monitoring Tool section of the QA Plan Matrix added 96 more. Conducting a review of this amount of data can be overwhelming. The Facility should consider refinement of these key indicators as, in their present form, many just track 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. It is generally considered a good practice to describe a key indicator in such a way that data can measure improvement or regression of whatever is being measured. The Facility probably has too many items identified in its QA Plan Matrix (388). 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 IID population at the Facility at the time of this review was 66. It would appear the Facility could organize its QA data analysis process to target the issues most compelling to those Individuals living at the Facility. With 388 items in its QA Matrix it may be difficult for users of the data to distinguish the critically important indicators from indicators that track less important matters. The Facility may want to consider reviewing the organization of key indicators such that those of major importance are in some way highlighted. Or, it may be possible to view some indicators as a subset of a larger more broadly defined key indicator in which case it might be possible to display key indicators organized around major topics. 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 has been corrected. 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. Recent changes in	

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		some staff assignments show promise in this regard. The QA Department now has a fulltime data analyst devoted to the IID QA Plan as well as a fulltime Settlement Agreement Coordinator (SAC). The duties of the SAC were previously the responsibility primarily of the QA Director. Despite these recent changes, the Facility acknowledged that implementation of inter-rater reliability is still variable by SA Section but had improved from that observed at the last review. The QA plan matrix identified 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. The QA Plan Matrix included 96 items related to SA Monitoring Tools and 292 items related to Key Indicators. During this review the Monitoring Team identified 16 of the 96 (17%) QA Plan Matrix items related to SA Monitoring Tools as including inter-rater reliability. This included Monitoring Tools associated with 12 of 19 (63%) of the SA Sections. The Facility did not appear to have a comprehensive monitoring tool to assess its progress towards implementing its QA program and meeting all SA requirements associated with Section E. None of the 292 key indicators had inter-rater reliability. The Facility acknowledged that continued development and implementation of inter-rater reliability processes was the most significant barrier to full implementation of the QA Plan. For the 20 sections of the Settlement Agreement, a set of key indicators were included for all of the 20 sections (100%). As noted above, in their present form they often just track counts of various events. It is generally considered a good practice to describe a key indicator in such a way that data can measure improvement or regression of whatever is being measured. The QA plan matrix did include all self-monitoring tools and self-monitoring procedures. All data that QA staff members collect were listed on the matrix. The Facility did not maintain a data list/ inventory. When questioned about this the QA Director reported that the QA Matrix (which includes the key indicators) described all data collected by the QA Department and this served as a Facility based data list/inventory. The purpose of compiling a data list/inventory is to enable the QA Department to be aware of various databases and other data sources that are maintained at the Facility, or maintained by DHHS/DADS, that may include data sets useful to the overall QA process. The QA Director acknowledged the need to expand the Facility's data list/inventory to include these types of data sources. Of the 388 items in the QA plan matrix (which included the 292 key indicators), 367 (95%) were submitted/collected/received by the QA department for the last two	

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		reporting periods for each item (e.g., monthly, quarterly). This compares to the 94% noted in the last report by the Monitoring Team. Examples of reports not submitted/collected/received included some inter-rater reliability data (where it had been determined inter-rater reliability should be occurring), some key indicator data for Section N, and some QA Plan matrix data for Section M. Of the 388 items in the QA plan matrix, 367 (95%) 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). This compares to the 18% noted in the last report by the Monitoring Team. This is an example of the maturation of the Facility's QA process from that observed at the last review by the Monitoring Team. 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 96 self-monitoring tools used for the SA sections, (a) the content of 96 (100%) appeared to be appropriate. Not all 96 had been reviewed (and revised as appropriate) within the past six months but the QA Director reported that as concerns were noted they were reviewed and modified. These concerns would typically be identified in meetings between the Section Lead and QA staff or at SA-PIC meetings. For example, the Monitoring Tool used for Section C was modified after audit results presented to SA-PIC revealed some important information was not included in the Monitoring Tool. Of the 96 self-monitoring tools for the SA, the Facility reported 15 (16%) had adequate instructions for the user. This compares to 24 and 38% noted in the last report by the Monitoring Team. QA staff had been more diligent in ensuring staff using various monitoring tools get adequate instruction in their use, and that the QA staff is holding staff to a higher level of accountability in using monitoring tools correctly. None of the instructions for use of monitoring tools were in written form. 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) 19 (100%) were implemented as per the QA plan (e.g., number, schedule, person responsible). This compares to the 17 and 89% noted in the last report by the Monitoring Team. 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 compares to the 100% noted in the last	

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		report by the Monitoring Team. This occurred at the SA-PIC meetings. Based on this review the Monitoring Team determined this Provision was not in compliance. Implementation of inter-rater reliability was deficient in the current QA system and is the primary barrier to compliance with this Provision. Inter-rater reliability is necessary to ensure validity of data. The Monitoring Team is hopeful that with the continued maturation of the QA system, the additional staff resources, 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. In its last report the Monitoring Team noted inconsistency in how this occurred SA section to SA section, and within reports associated with a SA section. This was much improved from that observed in the last review as reported in Provision E.1 and below. Data from the QA plan matrix for 17 of the 19 (90%) 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 where appropriate. The exceptions were Sections I and N. This compares with the one and 5% noted in the last report by the Monitoring Team. 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. The Facility reported this occurs to some extent in the monitoring of Section I but addressing this topic is still in the early stages. 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 each committee for the IID 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 included: Human Rights Committee (weekly); SA-PIC (2x/month); 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	Noncompliance

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		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: 1. Review of the data listing inventory and matrix, 2. Discussion of data and outcomes, 3. Review of the conduct of the self-monitoring tools, 4. Development of necessary corrective action plans, 5. Review of previous corrective action plans. Since the last onsite review, a meeting occurred between QA staff and department/discipline staff to review the above items at least twice for 19 of the 19 (100%) sections of the SA. This compares with the 100% noted in the last report by the Monitoring Team. The Facility reported these meetings occurred monthly. Since the last onsite review, during all (100%) of the SA-PIC meetings, minutes showed that relevant data were available to facilitate department/discipline analysis of data. Improvement in consistency was noted from that observed at the last review. Since the last onsite review, during all (100%) of the SA-PIC meetings, minutes showed that data were reviewed and analyzed. Improvement in consistency was noted from that observed at the last review. Since the last onsite review, during all (100%) of the SA-PIC meetings, minutes showed that action plans (CAPs) were created as appropriate and consistent with Facility guidelines for systemic problems and for individual issues. As reported in Provision E.1 the Facility needs to broaden its guidelines with respect to identifying systemic problems. Improvement in consistency was noted from that observed at the last review. 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 meeting. Minutes of the meetings reviewed by the Monitoring Team and observation of the meeting held during this review demonstrated good attendance and active engagement from those attending including comments on what factors may have contributed to progress and what factors may be impeding progress. Despite the presence of data reports much discussion focused on anecdotal information. The Facility needs to take steps to ensure that the SA-PIC uses the data developed (with accompanying analysis) by the QA Department in its review of	

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		progress or lack of progress in achieving compliance targets and other goals of the organization. Additionally, most discussion concluded with "do we need a CAP" rather than an overall assessment of progress and improvement action steps that could be contemplated in determining the need for a CAP. In its last report the Monitoring Team noted that QA reporting was not necessarily or typically associated with Settlement Agreement sections/topics. In fact, it was more likely to be organized around the reporting teams established as part of the Facility's performance improvement program. QA reporting had been modified and is now organized, for the most 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. This compares to the 100% noted in the last report by the Monitoring Team. Of the 19 sections of the SA that were presented at the SA-PIC: 1. All contained self-monitoring data. In most cases this was reported for a rolling 12 months or more and was broken down by program areas, living units, work shifts, etc., as appropriate 2. All reported key indicator data. In most cases this was reported for a rolling 12 months or more and was broken down by program areas, living units, work shifts, etc., as appropriate 3. All contained narrative analysis. In most cases this was reported for a rolling 12 months or more and was broken down by program areas, living units, work shifts, etc., as appropriate. An example were data organization was insufficient was in Section N, Pharmacy Services due primarily to staffing issues. In its last report the Monitoring Team noted that 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. This was much improved. The new comprehensive QA policy clearly articulates a description of the SA-PIC and expectations for its work. Since the last onsite review, the SA-PIC did meet at least once each month. Minutes from all eight (100%) SA-PIC meetings since the last review indicated that the meeting occurred according to schedule. Minutes from all eight (100%) SA-PIC meetings since the last review indicated that the agenda included relevant and appropriate topics.	

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		Minutes from all eight (100%) SA-PIC meetings since the last review indicated that there was appropriate attendance/representation from all departments. Minutes from all eight (100%) SA-PIC meetings since the last review documented that (a) data from the QA plan matrix were presented, (b) in most cases the data presented were trended over time, (c) comments, interpretation, and analysis of data were presented. In all eight meetings (100%) SA-PIC, recommendations, and action plans were developed when appropriate to do so, and were based, for the most part, on the data presented supplemented with anecdotal information. During a SA-PIC observed by the Monitoring Team, there was active participation of participants other than the presenter of reports and data during the meeting. In this particular meeting the discussion did not lead to the development of any formal action plan or a CAP. Throughout the meeting different members indicated they were going to follow-up on something, check on something, retrain certain staff groups, etc. This appeared appropriate to the Monitoring Team. An adequate written description did exist that indicated how CAPs are generated, including the criteria for the development of a CAP. In its last report the Monitoring Team noted that the Facility generated a large number of CAPs directed at administrative errors/omissions by particular staff persons and that the Facility reported it had engaged in a CAP Reduction Initiative to better define the types of circumstances where a CAP is an appropriate mechanism for corrective action planning. It appears this had been effective as the number of CAPs was much less than that noted in previous reviews but newly initiated CAPs still were not, for the most part, focusing on broader systemic issues. It is important that CAPs aim at system improvement. Then performance related to an issue/problem can be tracked over time and addressed as needed until an acceptable level of performance is maintained without respect, necessarily, to an individual staff performance issue that may contribute to improvement or lack of improvement. Individual staff performance is obviously important but ordinarily would be monitored through administrative systems associated with human resource and competency based training department processes. 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 still needs to better define CAP criteria to focus more on the problem needing to be addressed and less on a specific employee, or set of employees, that did, or didn't, do something correctly or incorrectly.	

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		Of the 11 CAPs reviewed by the Monitoring Team, 11 (100%) appeared to appropriately address the specific problem for which they were created. As described above, these CAPs often addressed employee performance issues or single issues effecting one Individual. For example, in reviewing the five most recently initiated CAPs three (60%) were for individual employee or Individual issues. CAP 2343 addressed the need for the home manager to take administrative action on an employee for confirmed abuse. CAP 2345 addressed the need for an IDT to meet to address one Individual's falls. CAP 2356 addressed the need for the home manager to take administrative action on an employee who did not provide 1:1 supervision. In its last report the Monitoring Team noted that the Facility had a basic framework in place for CAP management but may have suffered from ineffective oversight of the process and that this may have been the result of too many CAPs directed at managerial oversight functions rather than significant programmatic and clinical systemic trends. To some extent this is still the case but because the Facility had fewer CAPs (with many employee issues now apparently handled through other means) the Monitoring Team was able to see that the overall CAP management system had become less cumbersome and more manageable. Based on a sample of 11 CAPs: • Eleven (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. • Nine (82%) included the anticipated outcome of each action step. This was not the case for documentation provided for CAP 2348 and 2352. All CAPs had only one action step, for example, retraining a specific employee. • Eleven (100%) included the person(s) responsible for implementation. In each case this was determined by identifying the name the email titled Notice of Recommendation was addressed to and assuming that was the responsible person. The Notice itself should identify the responsible party and supervisor. • Eleven (100%) included the time frame in which each action step must occur. The system for tracking 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: • 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	

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		that ties them back to SA sections but this is expected to occur soon. • 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. • High priority open CAPs whose completion is delinquent by more than 30 days (or any other time oriented variable). • Low priority open CAPs whose completion is delinquent by more than 30 days (or any other time oriented variable). • 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 was variable department to department. Additionally data used to trend systemic issues did not appear to be used to develop broader based CAPs directed at the IID program of the Facility. CAPs continued to be singularly focused almost exclusively on employee related performance issues or similarly related administrative issues which are typically addressed through the supervisory chain of command.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	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.	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.	The Facility maintained a good system for tracking the status of CAPs. This included regular review at IMRT meetings which occurred daily and the two times a month SA-PIC meetings. 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 the SA-PIC no less frequently than monthly. The Facility data system could provide reports showing which open CAPs were not timely (i.e. late), by how many days, and the staff person responsible for the CAP. For example, upon request the Facility produced a report for the Monitoring Team showing that as of 5/21/14 eight CAPs were overdue 10-29 days and 11 CAPs were overdue 30+ days. The report included the names of responsible staff.	Noncompliance

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		The Facility had an ongoing program of conducting CAP Completion Audits. These are done by the QA Director. Each month 10 completed CAPs are audited to validate that the CAP was appropriately disseminated to a specific person with a copy to that person's supervisor (Provision E.3), whether or not the CAP was completed timely, and whether or not the CAP was completed fully, meaning all action steps occurred and were supported with appropriate documentation. If, in a given month, the number of completed CAPs was large the audit may include more than 10 completed CAPs. Results from the CAP audits were regularly reported to SA-PIC. The Monitoring Team sampled five CAP completion audits and validated each correctly measured what was intended to be measured. The Monitoring Team reviewed CAP Completion Audits for February, March, and April 2014 and found: • 45 Caps had been closed during this three month period. • 35 (78%) were audited. • 23 of the 35 (66%) were completed timely. This compares to the 60% reported by the Monitoring Team in its last review. • 35 of the 35 (100%) were completed fully. This compares to the 93% reported by the Monitoring Team in its last review. The high degree of compliance with CAPs being fully completed is not unexpected for two reasons: • Generally they are not closed until all action steps have been completed. • 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. Every action plan reviewed by the Monitoring Team was not complicated and did not involve multiple action steps involving multiple departments or disciplines. 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 during each review period since this policy was effective. While the Facility is to be commended for the system it has put in place to identify the	

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		need for a CAP, track CAP assignments and completion status, periodically review CAP status, and require evidence to substantiate CAP completion, as noted in previous reviews there remains 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 which are positive steps that should lead to compliance in future reviews. As noted in the previous reviews, to achieve compliance, the Facility must ensure CAPs are completed timely. 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. Because most CAPs still address single issue topics, as opposed to systemic trends, complying with this component of this Provision remained a challenge. 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.	None of 11 CAPs (0%) reviewed included documentation which would demonstrate they were effective (i.e. positive sustained outcomes). Since most addressed single issue topics what was measured was that the CAP directed activity did or did not occur, for example, the IDT met, or the administrative action with an employee happened. Until the Facility becomes more adept at identifying underlying systemic issues based on trend analysis and performance outcome metrics it will continue to be difficult to ascertain "effectiveness". None of the 11 CAPs in the sample required modification. This was likely because the CAPs were directed at a single instance of employee or IDT performance. Consequently action plans typically consisted of one action. 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. The Facility identified three CAPs (outside the sample) that were formally evaluated and determined to be ineffective. These were CAPs 2117, 1872, and 1907. In each case a modification to the CAP was initiated. This was a relatively new process for the Facility. Data associated with this process was not well organized or understandable. The effectiveness audit concluded with a "yes" in the "CAP Modification Required" column but	Noncompliance

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		a different set of work papers (Notice of Recommendation emails) were provided to the Monitoring Team to validate CAP modification after this determination. The Notice of Recommendation did not reference a CAP number or otherwise reference that this CAP was a modification to a previously implemented and reviewed CAP. This was all very confusing to the Monitoring Team and likely so to staff involved in implementation. The Facility should develop a clearer way of displaying the flow of CAP reviews and related conclusions that determine that a CAP was effective or ineffective, and if ineffective whether it was modified or not, and if not modified the rationale behind that decision. As reported in previous reports, 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 and in Provision E.4, 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 singularly 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.	

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 5/7/14 2. RGSC Action Plans 5/7/14 3. Provision Action Information for Section F 4. Presentation Book Section F 5. DADS Policy 004.2: Individual Support Plan Process 11/21/2013 6. RGSC Standard Operating Procedure (SOP) ICF-IID 600-01 Individual Support Plan Process (August 2012) 7. RGSC SOP ICF-IID 200-01 Most Integrated Setting, March 2014 8. Any tools used to measure QIDP competency with regard to (a) the facilitation of ISP meetings; and (b) the writing of ISP documents. 9. Information or training handouts for December 2013 training by State Office on ISP training manual, and list of participants 10. Alphabetical list of each individual at the Facility, with the most recent ISP meeting date, the date on which the ISP document was completed/filed, and the date of the previous ISP meeting date 11. List of individuals admitted to the Facility and date of admission 12. Monthly Attendance by Discipline 10/1/13-4/30/14 PSP's only 13. ISP Assessment Report (tracking log) November 2013 through March 2014 14. 2014 Assessment Report for reports due May 2014 as of the compliance visit (undated) 15. Individual Support Plans (ISPs) and Supporting Documentation for Individuals #82 and #94 Documentation requested included: a. The full ISP document, b. All assessments considered during that ISP development process, c. The Preferences and Strengths Inventory, d. Local Authority 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. 16. For the last two individuals admitted, the new admission packet

	17. Signature sheet for annual ISP planning meeting for Individual #126 18. Signature sheet for 30-day ISP meeting for Individual #7 19. QIDP Monthly Reviews for Individuals in Samples O1, O2, O3, and O4 (Individuals #2, #5, #6, #19, #33, #46, #55, #60, #62, #74, #77, #79, #94, #98, #103, #115, #118, #126, and #145 20. Email of 5/15/14 from Joe Vasquez listing status of QIDP monthly reviews for Individuals #2, #5, #19, #33, #46, #60, #77, #79, #103, #115, #126, and #145 21. "ISPs Addressing Living Options" for Individuals #5, #11, #29, #51, #62, #79, #97. #101, #103, and #114 22. Texas Settlement Agreement Monitoring Instrument, Section F: Integrated Protections, Services, Treatments and Supports (Section F Monitoring Tool)—nine completed by George Romero (QIDP Manager) and nine completed by Rosa Sanchez (Quality Assurance) **People Interviewed:** 1. Joint interview of George Romero (QIDP Manager) and Rosa Sanchez 2. Joint interview of George Romero (QIDP Manager) and QIDPs Rebecca Olivarez and Daniel Perez 3. Vanessa Alvarez, Human Rights Officer (HRO) **Meeting Attended/Observations:** 1. ISP Annual Planning Meetings for Individuals #126 and #140 2. Admission ISP meeting for Individual #7 3. ISP Preparation meeting for Individual #85 4. Quarterly Psychiatric Review for Individual #51
	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. Although the Self-Assessment did not specify a monitoring tool for most items that appeared to have been identified through audits, several reported items could be found on the Settlement Agreement Section F: Integrated Protections, Services, Treatments, and Supports tool. In additions, the Self-Assessment did report on the use of the Section F Monitoring Tool in relation to Provision F2g; only overall percentages were presented. 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 It was unclear from the Self-Assessment whether the monitoring tools included/ adequate methodologies or were simply reviews of documents. Interviews revealed they were reviews of documents for the most part. However, they did involve review of a range of documents that were part of or supported individual support plans. There was no report of observation of meetings to evaluate integrated discussion and planning. 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 adequate

	to consider them representative samples. o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. Interview with the Quality Improvement Manager indicated the raters had rationale for their decisions and a process for review, but these were not written, so the Monitoring Team could not determine how consistently these were followed or how specific they were. o The following staff/positions were responsible for completing the audit tools: Quality Improvement Manager and Program Improvement Manager 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, except for reported reliability for the Section F Monitoring Tool. Agreement was 79% on that tool, which is slightly below the generally accepted threshold. • Used other relevant data sources and/or key indicators/outcome measures. These included data on attendance at ISP meetings, timeliness of completing assessments, and percent of staff who had completed training. • 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. Per review of the Self-Assessment and interview, it was not clear that the indicators had been defined to make them specific. o Consistently did not measure the quality as well as presence of items. It was often difficult to tell whether the data measured quality. For example, the Facility reported the percent of sampled ISPs that included all necessary supports to meet the needs of individuals. That could be considered a measure of quality if there were clear criteria on which to base a determination of whether all necessary supports were included. The Facility did not provide, and the Monitoring Team did not request, such criteria, but based on interview, it was not clear that there were such criteria. Furthermore, the findings of the Monitoring Team did not always match the findings of the Facility. For this specific example, under Provision F2a2, the Facility found 94% of sampled ISPs included all necessary supports to meet the needs of the individuals; the Monitoring Team did not find that necessary supports consistently met the needs of individuals. • The Facility rated itself as being in compliance with the following provisions of Section F: Provision F1a, Provision F1e, Provision F2d, Provision F2e, and Provision F2f. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with no provisions of Section F. For Provision F1e, the Facility stated all sampled ISPs provided meaningful opportunities to develop new skills and increase opportunities for community integration and reflected that Individuals were provided with interventions and supports that are practical and functional for gaining skills in the community, whereas the Monitoring Team determined that this was not done consistently. It is unclear what criteria the Facility used in making its determination,

	and the Monitoring Team did not have adequate documentation to support that finding. 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. Many In Process actions were actually routine and ongoing actions rather than additional steps to improve processes, such as developing programs for individuals, reviewing or auditing ISPs, and submitting findings from reviews to the Settlement Agreement-Program Improvement Committee (the Facility's quality improvement council). • The Facility data identified areas of need/improvement. For example, for Provision F1d, the Facility reported noncompliance because ISPs were completed after the 30-day timeline in January and February 2014; the Facility put into place an action plan of reassigning the senior QIDP as the new QIDP Facilitator. This action was in addition to actions to develop the QIDP Facilitator position and to monitor ISPs to ensure the facilitation is completed, and it indicated a revision to the plan based on review of the monitoring. • 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 (although actually more relevant to Provision F1d), but there is no indication of what action steps will be needed to make this happen. Furthermore, the actions for Provision F1c are identical to three of the five actions noted in the Action Plan provided at the last compliance visit. Finally, the actions seem to assume that reporting to SA-PIC will result in further improvement actions. For many requirements, it would be useful to plan additional actions that would likely be needed to accomplish compliance.
	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. The Facility had revised its structure for developing ISPs. QIDP staffing was reorganized to have one QIDP Facilitator and three QIDPs. This had only been in effect for a few months. **Provision F1:** As noted above, the structure of QIDP assignments had changed. The QIDP Facilitator was responsible for the process of developing the ISP, with the other QIDPs putting more focus on the implementation and effectiveness of the ISP for individuals in their caseload. Attendance of IDT members at annual ISP planning meetings was good for nearly all disciplines. Timeliness of completing assessments continued to need improvement. Completion of assessments for individuals on admission had improved. Comprehensiveness of assessments varied across disciplines. Use of results from assessments to develop, implement, and revise ISPs was variable; IDTs did not consistently use the available results appropriately to develop, implement, and revise the ISP as necessary. 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. **Provision F2:** ISPs were revised annually, and ISP meetings for newly admitted individuals were consistently held within 30 days. Implementation of ISPs was not consistently in place within 30 days following the planning meeting. 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 did not describe the methods and strategies, the responsible individuals, or the timelines, and other documents that might have included those were not consistently provided for review. There were signs that improvement in integrated planning is continuing. 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. Monthly reviews of progress were not consistently completed each month as required. Reviews of action plans, which were done monthly for each action plan, did not include data and usually did not include an assessment of progress. Overall, reviews did not provide information on progress or regression and served primarily as a reporting and documentation mechanism with little evidence of their use to track progress and plan revisions to supports and interventions.

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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. Beginning in July 2014, the Facility had revised its structure for developing ISPs. One of the four QIDPs was assigned the role of QIDP Facilitator. Per interview with the QIDP Manager, this was intended to improve the timeliness of the information in the ISPs and consistency of the way in which meetings were held. This was also intended to permit the other QIDPs to focus more on the individuals in their caseload, for example, to focus more attention on injuries. The QIDP Facilitator was relieved of her caseload, which was shifted across the three QIDPs who	Noncompliance

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		were responsible for 22 or 23 individuals each. QIDPs continued to lead the 90-day pre-ISP preparation meeting that identified issues to be addressed, disciplines that needed to attend the ISP planning meeting, and assessments needed in advance of that meeting. The QIDP Manager supervised the four QIDPs, including the Facilitator. Observation at two annual ISP planning meetings and the 30-day admission ISP planning meeting confirmed that the QIDP Facilitator was the team leader responsible for ensuring team participation and facilitating involvement of IDT members; the QIDP was also present and participated actively in each meeting. DADS policy 004.2 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 Individual #140 participated actively. <u>Process of determining competency of QIDPs in the facilitation process</u> In response to a request for tools used to measure QIDP competency with regard to (a) the facilitation of ISP meetings; and (b) the writing of ISP documents, the Facility provided a document titled "QIDP Role and Responsibilities in ICF-IID Regulations" that consisted of the ICF-IID requirements relevant to the work of QIDPs from the Federal ICF State Operations Manual. There was no description of the process for evaluating competency, nor was any examination or observational tool provided. The Facility reported that all four QIDPs had been found competent. At the last visit, the Facility reported it had used the Q Construction Facilitation curriculum for training in this area and for evaluating competence and had conducted an annual competency recertification check during that review period, which would be within the past year. As will be evident from findings of other provisions of this Section, this remained a work in progress. The Facilitation process was still in an early stage, and improvement remained needed in the structure and process of the annual ISP planning meeting. Remaining deficiencies that continued to need improvement included: • For none of the two plans reviewed (0%) did the facilitation process result in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. The assigned QIDP remained responsible for monitoring and revising treatments, services, and supports. The Monitoring Team found in its review that the QIDPs did not yet consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed as described below under Provisions F2a6 and F2d. • 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.	

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		Nonetheless, it is promising that the Facility is taking action to improve and is reviewing the effectiveness of the process. For example, the Facility's tracking of timely completion of assessments, while showing an average over the review period of 43% of assessments completed timely, showed improvement in March and April 2014. The Facility also reported that the QIDP Facilitator leads a weekly peer review meeting with QIDPs and Nurse Case Managers to discuss information in Integrated Risk Review Forms (IRRFs) that may need to be updated or added for an individual who is scheduled for and annual ISP meeting a month later, with special focus on individuals at higher risk in some area(s).	
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 004.2 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 #85, 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 the "Monthly Attendance by Discipline 10/1/13-4/30/14 PSP's only" table. This table listed required participants, number of meetings required for each, the number attended each month, and the percent of required meetings attended. Staff, LARs, and others could attend non-required meetings but would not be counted on this table; for example, the HRO reported she attended many more meetings than required but was counted on this table only for those she was required to attend. According to the table, overall attendance at required meetings was 95%. Percent attended ranged from 60% for physicians and 76% for the individual to 100% for over half the participant categories (disciplines, families/LARs, individuals, local authority representatives, and certain other staff). The Monitoring Team did not review the lists of attendees determined at the ISP preparation meeting to be required. As the "QDDP" and Nursing were listed at required for 37 meetings, which appeared to be the total number covered by the table. The physician was required to attend 10; depending on the needs of individuals, this might or might not be an appropriate number. The Primary Care Provider (physician) was present at the annual ISP meeting observed for Individual #126, who had significant medical issues that needed to be addressed. Similarly, the dietitian/nutritionist was required at 17 meetings; given the needs of individuals, this may or may not be	Noncompliance

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		appropriate. Most other disciplines were either required to attend most meetings or shared that duty (e.g., physical therapist and occupational therapist sometimes represented both disciplines, Psychology Assistants often represented Behavioral Health Services). The Psychologist/Behavioral Analyst was only required to attend two ISP meetings. Given the complex behavior problems exhibited by many individuals at the Facility, representation by the Psychology Assistant may not be adequate in all cases; instead, participation by the Behavior Analyst for individuals with complex or injurious maladaptive behaviors should be required. For example, Individual #7 exhibits dangerous problematic behaviors, according to reports at the admission ISP planning meeting. As a result, the IDT decided to limit activities to on-campus for the time being. If the behaviors are significant enough to require this restriction of rights and of opportunities to learn community skills, the behavior clinician should be directly involved. In addition, the psychiatrist indicated the possibility of prescribing a new psychotropic medication; this should be done through joint case formulation with the behavioral health specialist, indicating a need for that clinician to participate actively in the IDT process. <u>Extent of Individual participation in ISP:</u> In addition to actual meeting participation by individuals, meaningful participation appeared to be improving as observed at on-site annual ISP meetings. This was particularly true for Individual #140. Although Individual #126 was present at the beginning of the meeting and again later, the length of the meeting prohibited the individual's attendance throughout; the Facility needs to consider how to structure meetings so the individual can be involved throughout.	
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 004.2 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. In addition, the Facility had established and implemented a new policy that addressed assessments, RGSC SOP 400 19 Minimum Common Elements of Care. This policy provides guidance for both scheduled assessments and "interval" assessments. A detailed discussion of this policy is found in Provision G1. The policy brings together timeframes for required scheduled reports for various clinical disciplines. The Facility should check to ensure the timelines for assessments are consistent across all DADS and Facility policies.	Noncompliance

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		Extent to which assessments are conducted routinely 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 reviewed clearly defined the assessments that were to be completed. Overall, improvement is still needed in completing routine assessments. Assessments for the ISP were still not routinely completed on a timely basis. A sample of two recent ISPs found lack of completion of assessments in time to permit IDT review prior to the annual ISP planning meeting and in compliance with policy requirements. • 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 32 assessments that were required to be completed 10 working days prior to the ISP date, 18 (56%) were completed on a timely basis. This is consistent with the data provided in the monthly Assessment Reports table described below. The Facility provided a monthly Assessment Reports table reporting assessment completion for November 2013 through March 2014. 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 November and December 2013, and January, February, and March 2014 respectively, the percent of assessments completed timely was 50%, 53%, 36%, 58%, and 53%. This was, overall, a slight improvement compared to the findings at the last compliance visit. The Assessment Reports also reported the percent of assessments completed by the time the report was done (in the first week of the following month). This indicated many of the assessments were completed but had not been posted for IDT review 10 working days in advance of the ISP annual meeting. For ISP planning meetings held in November and December 2013, and January, February, and March 2014 respectively, the percent of assessments completed was 74%, 80%, 70%, 91%, and 80%. The range was greater than that found in the last compliance visit and was overall slightly lower for the current period. Completion of assessments was variable across disciplines. Some disciplines consistently completed assessments on time. For example: • Seven of eight individuals' OT/PT assessments reviewed (88%) were dated as	

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		having been completed at least 10 working days prior to the annual ISP. • According to the Assessments Report, nutritional assessments were consistently timely. Other examples indicated a need for improvement in completing annual and quarterly assessments and updates timely: • As reported in Provision K7, psychological assessments were not consistently completed annually. Furthermore, there was often not documentation of intellectual assessments within the prior five years or of annual adaptive assessments. • As reported in Provision M2, It was apparent through review of the Self-Assessment, interviews with Nursing Administration, and review of documents that concerted efforts had been made to improve the timeliness of the Annual/Quarterly Nursing Assessments. At this compliance review there was no appreciable improvement found with this Provision. One of two (50%) Annual Comprehensive Nursing Assessments in the reviewed sample that were due were completed on time, according to Facility policy. Two of three (67%) Quarterly Comprehensive Nursing Assessments due were completed on time, according to Facility policy. • For eight of 13 individuals in Samples R.1, R.2, R.3, and R.4) (62%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP However, seven of seven communication updates/assessments (100%) were completed consistent with the established schedule, or the individuals' need. It should be noted that 100% of the assessments completed post January 2014 were completed in a timely manner. • According to the Assessments Report, disciplines completing assessments timely for less than half the annual ISP meetings included medical, psychiatric, and psychological. • As reported in Section S, during the current visit, the Facility was asked to provide ISP documentation, as well as associated assessment reports and skill acquisition programs, for 10 individuals living at the Facility. Included in this request were Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. Three document requests were eventually submitted: one submitted on-site and two follow-up requests submitted following the site visit. For no individual were more than 43% of the required assessment reports submitted. Furthermore, none of the 14 types of assessment reports (0%) was submitted for all individuals in the sample. On the other hand, there was improvement in completion of assessments when individuals were admitted.	

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		• For Individual #103, the Facility provided a list of assessments to be completed before the admission ISP meeting and of those completed as of 5/21/14. Only four of 15 assessments (27%) were dated at least five working days prior to the meeting. • The Monitoring Team reviewed all admission assessments for Individual #7; all were completed within 30 days of admission. Nine of 12 (75%) were completed at least five working days prior to the admission ISP meeting; one additional was undated, and two were completed the day of or day before the admission ISP meeting. • The report provided by the Facility did not report the Psychological Assessment for Individual #103 was completed, although, as noted in Provision K7, a tracking list reported the Behavioral Health Assessment had been completed within 30 days following the ISP meeting. The Behavior Health Assessments for the new admissions (#38, #62, and #103) were all dated within 30 days of admission per the assessment tracking information provided. • Four of four OT/PT assessments for newly admitted individuals (100%) were posted a minimum of five working days before the admission ISP meeting. • Four of four (100%) Admission Comprehensive Nursing Assessments were completed within 30 days of admission. All were completed at least five working days prior to the admission ISP meeting. The Facility has put into place actions intended to improve timeliness of assessments. The QIDP Facilitator model has been implemented, with one QIDP facilitating all annual ISP development. This provides one staff who focuses on getting the required documentation and facilitating the ISP planning meeting. Also, a reminder is now sent to psychiatrists 20 days prior to the ISP meeting. <u>Comprehensiveness of Scheduled Assessments</u> Comprehensiveness of assessments varied across disciplines. Some were generally consistent with requirements, others had most but not all required components, and others continued to miss important components. Furthermore, the Facility did not provide all assessments requested by the Monitoring Team. • As reported in Provision K7: o Structural and Functional Assessments (SFAs) were comprehensive and included all required behavioral components. They included some presentation of mental illness diagnoses and potential relationships between environmentally based behavior and symptoms of mental illness. However, the Facility did not provide all the requested sample of SFAs. The Monitoring Team could not determine whether the missing SFAs had been completed or were comprehensive.	

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		○ 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. For the sample reviewed, nearly all assessments included documentation of intelligence testing within the prior five years, but a minority provided documentation of assessment of adaptive skills within the prior year. • As reported in Provision P1, some components of comprehensive OT/PT assessments were consistently present, but many components were not. Inclusion of comparison of status from year to year had shown improvement in the past but had declined since the new assessment format was implemented at RGSC. PT/OT assessments reviewed did not include specific measurements when assessing spasticity. • As reported in Provision R2, the speech assessment continued to show improvement but still needed to do a better job in providing better guidance into how strategies and recommendations should be integrated into the daily schedule. • Annual medical assessments did not always include all appropriate examinations. ○ For individuals with cerebral palsy, the Medical provider documented regular assessments for the potential manifestations of CP in zero out of five examples (0%). ○ For individuals with osteoporosis, 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. • A review of the Admission, Annual, and Quarterly Nursing Assessments for timeliness, content, and quality found no appreciable improvement from the last compliance review. Findings included: ○ Four of eight (50%) of the nursing assessments did not include the quarterly physical assessments that are required by the DADS Guidelines for Comprehensive nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment. For individuals who had been recently admitted: • Four of four newly admitted 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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		• Behavioral Health Assessments had been completed.
		  o Two of four individuals (50%) had been provided an assessment of adaptive skills. Although the admission Behavioral Health Assessment for Individual #7 provided an Adaptive Behavior Level, it gave no information about specific adaptive behaviors or areas of strength and need.
		  o Four of four individuals (100%) had been provided an assessment of intellectual ability.
		  o Four of four individuals (100%) had assessments compiled and interpreted within a written assessment report.
		
		<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>
		Preferences identified in the Preferences and Skills Inventory (PSI) and other assessments were not always addressed by relevant clinical or discipline assessments. For example:
		• For Individual #82, the PSI indicated the individual had stated a preference for a job working with animals. The Vocational Assessment did not reference this preference, nor was any vocational exploration documented or barriers thereto offered.
		
		<u>Extent to which comprehensive assessments are conducted timely when there is a significant change of status for an individual</u>
		Assessments were conducted timely when the IDT identified a change of status for an individual.
		• As reported in Provision O2, the Physical and Nutritional Management Team (PNMT) initiated an assessment within five working days of a referral or sooner as specified in the PNMT policy.
		• As reported in Provision L1, ten out of 11 acute medical conditions reviewed for a sample of individuals (91%) included a comprehensive and clinically appropriate initial assessment of the acute medical condition. Initial assessments by the medical provider were timely, clinically appropriate, and indicated the need for consultations and, or diagnostics, when clinically necessary.	

F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and	<u>Extent to which assessment results are used to develop ISPs:</u> Current assessment practices, in terms of timeliness, accuracy and thoroughness, did not provide assessment results that could adequately be used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be	Noncompliance

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	supports to be provided to the individual.	provided to the individual. As described in Provision F1c, assessments required to develop an appropriate ISP meeting were frequently not done in time for QIDPs to complete the ISP Guide five days before the ISP annual meeting that would have enabled IDT members to review before the meeting, nor were assessments completed with sufficient thoroughness. Use of results from assessments to develop, implement, and revise ISPs was variable. In some cases, results of assessments influenced ISPs. For example: • Assessment of three individuals who received enteral nutrition identified that three individuals might benefit from oral motor treatment. These three individuals who were identified as potentially benefitting from oral motor treatment or cleared to return to some form of oral intake (100%) had a comprehensive plan outlining the treatment or return to PO process, and the plans were implemented. • For six of eight individuals in Sample P.1 (75%), the ISP/ISPAs addressed each of the recommendations outlined in the current OT/PT assessment. While this did not yet reach a level of consistent use of information from assessments, it did show progress. Even when the results of this assessment process were used in the development of the ISP, the IDTs did not consistently use the available results appropriately to develop, implement, and revise the ISP as necessary. For example: • The Communication Assessment for Individual #82 noted several thoughtful and specific suggestions for IDT consideration related to employment, increasing leisure interests and increasing independence that were not acknowledged in the ISP. • At the ISP meeting for Individual #140, the IDT did not look in the record to determine the individual's current skill (for example, by reviewing the Functional Skills Assessment (FSA). Instead, the QIDP stated she would have to check the FSA (which indicated she would use information from the record, but which did not allow for that information to be provided to the IDT members for team decision on a goal). Although the Monitoring Team requested "Current ISP and all assessments developed for ISP meeting" for Individual #140, the SFA was not provided; therefore, the Monitoring Team cannot comment on how IDT awareness of the SFA would or should have affected IDT decisions at the ISP meeting.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. §	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	Noncompliance

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	12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	Monitoring Team found the required determination was still not being consistently provided. • Of the two ISPs reviewed, for neither (0%) did all of the discipline assessments include the applicable statement/recommendation. Of 14 total discipline assessments reviewed, 9 (64%) included a determination of whether the individual could be served in a more integrated setting. • Two of two ISPs (100%) did include 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 might be needed in the community. The Monitoring Team did note a positive step forward in the ISP for Individual #94, in that the QIDP had facilitated a thoughtful interdisciplinary discussion about the potential benefits of community living for Individual #94. • The Facility typically did not have an adequate basis for determining the preferences of individuals for living arrangements. As described in Provision T1b2, IDTs did not yet develop individualized plans for education and awareness that would be sufficient to meet the learning needs of the individuals residing at the Facility. The Facility provided 20 "ISPs Addressing Living Options." The Monitoring Team selected the first 10 of these, which were for Individuals #5, #11, #29, #51, #62, #79, #97. #101, #103, and #114. The supporting assessments were not provided, so the Monitoring Team could not determine whether they included determinations by each discipline. The Living Options Discussion section of the ISPs themselves documented determinations and recommendations for supports from some disciplines. • Individual #101 moved between the time the ISP was developed and the compliance visit. The Living Options section of the ISP was not completed, so the ISP did not document any determinations or recommendations. • Individual #103 had recently been admitted to the Facility. The IDT concluded that it was too early to make a determination. Therefore, the ISP did not document any determinations or recommendations. • The Living Options Discussion section was not completed for Individual #114. • For Individual #62, no determinations were documented, but there was extensive narrative documenting a discussion among IDT members and the LAR. • Determinations were documented for either four or five disciplines for	

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		Individuals #5, #11, #29, #51, #79, and #97. • Support needs, at least a limited set, were proposed by at least some disciplines for each of the individuals who had documented determinations. In most cases, the proposed support needs were specific to the discipline proposing them (e.g., nearly all needs proposed by the dietitian related to diet and eating, nearly all made by Speech involved either communication or PNM issues). • Of the six individuals for whom determinations were documented, determinations were provided by PT/OT for six, by the Dietitian for six, by the physician for two, by Nursing for one, and by the QIDP for six. Most determinations favored referral. No other disciplines were documented as making a determination. These findings are not consistent with the Self-Assessment, which states that all sampled ISPs contain recommendations in regards to the individual's ability to live in the most integrated setting. Although it is true that there are at least three such determinations in each ISP provided to the Monitoring Team, that is not a high percentage of the disciplines participating in the ISP process. When asked what criteria they use, the QIDP Manager said they look at documentation in the ISP summary and what is discussed during the meeting, and they also focus on preferences and strengths; they also look at skill acquisition programs to see if they include steps important for community. The documents provided to the Monitoring Team did not, for the most part, include the action plans, so it was not possible to review those. The preferences and strengths lists did not focus on preferences of living settings or environments, or on preferences that might help in identifying characteristics of preferred living environments. They included preferences such as posters, pictures of family, ice cream, cats, 80s music, dancing, and (a preference that could be important in identifying a possible work setting but was not referenced in regard to living option, vocational goals, or social skill development) helping office staff with their duties. The Facility did show signs of progress in meeting the requirements of this provision. • As reported in Provision P1: o Eight of eight individuals' OT/PT assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. o Eight of eight OT/PT assessments (100%) provided a statement regarding "Factors for Community Placement" that is detailed and lays out the supportive services needed for successful living. • During the annual ISP meeting for Individual #140, the QIDP Facilitator asked each IDT member to report a determination on the appropriateness of a move to a more integrated setting. Different clinicians reported different determinations.	

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		Some raised concerns and questions for discussion, such as what availability there would be of BCBAs to work with behavioral concerns. Although the IDT made a decision not to refer at this time, the discussion was substantive.	
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 community participation;	<u>Identification and Use of Individuals' Preferences and Strengths:</u> DADS Policy 004.2 describes the PSI as an on-going integrative assessment process that provides a written record of the resident's preferences, strengths, goals, programs, and supports provided at the State Supported Living Center and as the cornerstone of the Facility's person-centered processes. In previous reports, the Monitoring Team had found that there were significant deficiencies as to the extent to which ISP builds on the individual's preferences and strengths and prioritized needs. The ISP process relied, and continues to rely, heavily on the Preferences and Strengths Inventory (PSI) process to identify preferences and strengths, a process which did not involve formal assessment of preferences or reinforcers, but relied largely on anecdotal information. A widely recognized procedure or tool for identifying preferences was not used. In the current ISP process, the IDT began with a discussion of preferences and strengths. It was not yet evident the Facility was proficient in completing this assessment, as evidenced by the outcomes. Preferences continued to be largely focused on favorite foods and environmental likes and dislikes. The IDTs should expand their approach to include a more thorough examination of where and how an individual would like to live, what kind of work and/or avocation is meaningful to the individual, preferences related to social interactions beyond the basics of enjoying staff interaction and/or personal space, and how individuals relax and/or spend spare time. If these preferences are not known or cannot be discerned, this should indicate to the IDTs a need to implement Action Plans to help the person discover them.	Noncompliance

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		When identified, the IDT should use individuals' preferences and strengths to develop purposeful, related action plans. The Monitoring Team observed some Action Plans related to preferences in a review of two ISPs; however neither (0%) had effectively carried out this responsibility. For example: • Individual #94 enjoyed having nails and hair done, as well as shopping for clothes. The IDT did develop Action Plans for these to be done in a community setting, but did not integrate these preferences with a separate money management SAP. This would have been an example of using preferences and strengths to build and reinforce skill community living skills in a measurable way. • Individual #82 was reported to have several preferences that were not addressed, including, for example a stated preference for a job working with animals and a desire to visit the humane society. The IDT did not reference these preferences in the ISP nor develop any Action Plans related to them. Similarly, the PSI indicated he enjoyed action movies and would like to go to a basketball game, but there were no related leisure Action Plans developed other than to play soccer with a peer, with data to be collected once per week. <u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed:</u> • The Facility IDTs had begun to identify needs that would not be considered priority needs and provide a rationale for these decisions. • Aside from barriers related to the most integrated setting, ISPs did not typically list barriers. In none of two ISPs (0%) were barriers adequately identified and addressed. 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 reported in Provision T1b1, the Monitoring Team found that obstacles to transition to the most integrated setting were not consistently appropriately identified or addressed. None of two (0%) recent ISPs reviewed evidenced proficiency in this regard. See Provision T1b1. <u>Extent to which ISP encourages community participation:</u> • None of the two ISPs (0%) reviewed included a specific skill acquisition action plan 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. Individual #94 had a SAP to hand money to a cashier for purchases in the community, but the Action Plan specified no expectation as to how often this would occur. • Individual #82 had no SAPs to be implemented in the community, nor any specific Action Plan for community participation. The IDT noted in the ISP that	

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		Individual #82 enjoyed a number of community activities, but there were no community Action Plans related to these leisure interests. The only references to community participation was for the Special Considerations to be revised to indicate the individual would be encouraged to shake hands in greeting in all settings, as well as for staff to use the individual's communication strategies in all settings. See also Provision F2a1. • 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;	The parties agreed the Monitoring Team would conduct reduced monitoring of this provision, because the Facility reported it had made limited progress. The noncompliance finding from the last review stands. <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> 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. <u>Adequacy of processes for identification of and plans to overcome barriers</u>: In the section below that addresses Provision T1b1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. This also requires the development of action plans in ISPs. In summary, barriers to living in the most integrated setting did not always lead to relevant 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	Noncompliance

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		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 yet consistently appropriately identified or addressed. Also see Provision F1e above.	
	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 Neither of the two (0%) plans reviewed for this section adequately integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual, although some progress was noted. For example: • As described in Provision F2a1, Individual #94 enjoyed having nails and hair done, as well as shopping for clothes. The IDT did develop Action Plans for these to be done in a community setting, but did not integrate these preferences with a separate money management SAP. This would have been an example of using preferences and strengths to build and reinforce skill community living skills in an integrated manner.	Noncompliance

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		• The ISP for Individual #82 indicated in several instances that the individual's communication strategies would be integrated into various SAPs. The communication strategies, as found in the Communication assessment included the following: o Speak to individual using simple sentences to communicate when making requests, commenting or addressing the individual; o Ask the individual simple questions and elaborate on the topic; o Help the individual make choices throughout the day (dressing, meals and during activities); o Encourage the individual to elaborate on an activity. The SAPs were reviewed to determine whether this integration had occurred. Overall, the Monitoring Team found the IDT had some success in the integration of the communication strategies, although more integration was needed. Three of five (60%) SAPs included a reminder in the Special Instructions section for staff to follow the communications strategies, which may serve to prompt staff. Positively, SAP instructions were detailed as to how the staff should interact with and instruct the individual. These instructions typically incorporated the strategies of using simple sentences and asking simple questions. There was some use of the strategy for making choices, although the choice involved was usually simply whether or not to participate. The IDT should seek to expand upon this strategy in the design of the SAPs. The strategy for having the individual elaborate upon an activity was not observed to have been effectively incorporated. A continued significant area of deficiency was noted in incorporating medical issues and plans to address those into the interdisciplinary team process. Medical diagnoses, necessary treatments, medical follow-up, important monitoring and reporting parameters, and all necessary supports and services provided for each medical condition were not addressed on the annual medical summary, ISP, or IRRF, and not all were addressed at the ISP meeting. There was a lack of evidence of indicators being integrated as part of the Integrated Health Care Plans (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). For zero of two individuals (0%) in Sample O.2 (see Section O), all recommendations by the PNMT were addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. Recommendations were not clearly linked or integrated into the IHCPs. For example, Individual #79's criteria for reassessment by the PNMT were not included as part of the IHCP. For individuals who were not independent in communication, there was not	

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		documentation about how communication interventions were to be integrated into the individual's daily routine. There were also signs of continuing improvement in integrating protections, services and supports, and other interventions. • As reported in Section O: o For the one individual for whom head of bed evaluations (HOBE) were conducted (100%), the HOBE recommendations were integrated into individuals' plans. o 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 efficac**y** of the plan. o Three of three individual's plans to return to oral eating were based on the results of the IDT's discussion (100%) and were integrated in the IHCP, ISP, and/or an ISPA. • As reported in Section R: o ISPs 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**.** o Communication Dictionaries 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.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	<u>Adequacy of identification of time frames in action plans:</u> For one of the two ISPs reviewed (50%) did the action plans include adequate timeframes for completion. For Individual #82, timeframes were identified that varied with the activity defined in the Action Plan and these appeared to be appropriate. No timeframes were identified for Individual #94. <u>Adequacy of identification of persons responsible in action plans:</u> For one of the two ISPs reviewed (50%) the Action Plans indicated by position who would be responsible for program implementation, documentation and data review. 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. <u>Methods for implementation:</u> The ISP itself did not describe methods for	Noncompliance

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		implementation. As reported in Section F and in other places in this report, SAPs requested by the Monitoring Team were not consistently provided. Therefore, the Monitoring Team cannot comment on whether methods for implementation were provided in all cases. Direct Care Professional Instructions Sheets were not attached to the Integrated Health Care Plans reviewed, so the Monitoring Team also could not evaluate whether methods of implementation of health care supports and interventions were clear.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The parties agreed the Monitoring Team would conduct reduced monitoring of this provision, because the Facility reported it had made limited progress. The noncompliance finding from the last review stands. <u>Adequacy of interventions, strategies and supports that are practical and functional at the Facility and in community settings:</u> 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. None 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. As indicated above, the Facility did not provide SAPs that would permit a more thorough review of whether those were practical and functional.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	To assess whether the requirements of this provision were met, the Monitoring Team reviewed the ISPs and attached documents for Individuals #82 and #94. The Action Plan for Individual #94 was not completed and therefore did not identify data, frequency of data collection, person(s) responsible for data collection, or person(s) responsible for 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. Action Plans for Individual #82 listed the "Data Sheet/Documentation Form," which was always "SAP Data Collection Sheet," but not the actual data to be collected and monitored for progress. IHCPs did not provide information on clinical indicators for which data were to be gathered. <u>Extent to which ISP identifies the person(s) responsible for the data collection, and the person(s) responsible for the data review:</u>	Noncompliance

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		For one of the two ISPs reviewed (50%), the Action Plans defined the person(s) responsible for data collection. Similarly, for one of the two ISPs reviewed (50%), the Action Plans also clearly defined the person(s) responsible for data review.. Even for Individual #82, for whom this information was completed, it did not appear this was sufficient to achieve the outcomes of ensuring program review was accomplished as required, as evidenced by the findings described in Provision F2d below. Separate from the ISPs, other records, such as treatment plans and PBSPs, did identify the measures of progress, if not the person responsible for data collection. For example: • As reported in Provision K9, PBSPs provided for review (some were not provided and compliance could not be assessed) had operational definitions of target and replacement behaviors. The BCBA reviewed graphed data at least monthly. • As reported in Provision R3, review of the individuals' records from Sample R.2 showed the following: o For three of three individuals' records (100%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. o For three of three individuals (100%), information was present regarding whether the individual showed progress with the stated goal.	
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, including the development and monitoring of the IRRF, the Integrated Health Care Plans (IHCPs) and a variety of routinely scheduled cross-discipline meetings. Collaboration between Speech and Language and BCBAs appeared to be working well. Communication strategies identified in communication assessments were included in PBSPs and ISPs. As reported in Provision P2, in eight of eight of the ISPs or ISPAs reviewed (100%), skill acquisition programs or opportunities for skill acquisition that had been recommended in the OT/PT assessment were present. As described in Section J, collaboration between psychology and psychiatry continues to evolve toward collaborative case formulation.	Noncompliance

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		The ISPs reviewed for Individuals #82 and #94 indicated improvement in identifying areas for coordination, although room for further improvement remains. Overall, coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the ISP continued to be lacking, as described throughout this Section F and in other sections of this report. For example, as reported in Provision T1b2, the Facility should have, but did not create comprehensive coordinated plans for community living education and awareness for individuals. Other opportunities for coordination exist, such as coordinating money management and communication skill acquisition with preferred outings. Other examples of opportunities and ways to improve coordination of services are described in Provision F2a3.	
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> Much of the usefulness of the ISP is found in the instructions to staff who will carry out supports, services, treatments, and interventions. It is difficult for the Monitoring Team to assess that for this visit. SAPs were not consistently provided for review. Direct Care Professional Instructions Sheets were not attached to the Integrated Health Care Plans reviewed, so the Monitoring Team also could not evaluate whether methods of implementation of health care supports and interventions were clear. Although PNMPs, for the most part, appeared clear, implementation was not consistently accurate (although improved). Some essential plans, such as PBSPs, are not incorporated into the ISP. Assignment of responsibility in the ISP, if documented, is generally assigned to a job classification or shift, which could make it difficult for specific staff to know their responsibilities. 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. On the positive side, PBSP readability levels indicated they were written at a reading	Noncompliance

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		level that should make them accessible to staff who implement PBSPs.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	<u>Monthly review of progress</u>: 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. To determine timeliness of monthly reviews by QIDPs, the Monitoring Team reviewed monthly reviews requested for the last six months for 19 individuals. Two of those individuals moved to the Facility in December 2013, and reviews covering April 2014 were not available, so 93 monthly reviews should have been completed. The Facility provided 78 monthly reviews (84%). Of the 93 reviews, 34 (37%) were completed by the end of the month following the month reviewed. Forty-nine of 74 (66%) monthly reviews due through February 2014 were completed within two months. The monthly reviews reported on changes to, or review of, the Preferences and Strengths Inventory; most reports either gave a date with no comment or indicated no change. Many reviews listed incidents, peer-to-peer aggressions, medication changes, and/or comments and recommendations. Reviews of action plans, which were done monthly for each action plan, did not include data and usually did not include an assessment of progress. Common statements included, "Continue" and "Deleted." Some provided additional information such as, "QIDP will special staff. For Individual #60, the statements for the reporting periods of November and December 2013 for an action on identifying coins were "Continue with Program"; for the reporting periods of January and February 2014, the statements were "[Individual] refused to attend vocational. Schedule ISPA." No documentation of an ISPA meeting was provided. Overall, reviews did not provide information on progress or regression and served primarily as a reporting and documentation mechanism with little evidence of their use to track progress and plan revisions to supports and interventions. Detailed review of the monthly reviews was completed for Individuals #82 and #94. • For only one of two ISPs (50%) completed prior to the monitoring visit, was there evidence the QIDP had made a timely monthly review over the past three months. For Individual #94, the Facility provided Monthly Reviews for December, 2013, and for January and February, 2014 that were all dated 4-16-14. • Monthly Reviews for December, 2013, and for January and February, 2014, for Individual #82 appeared to be generally completed on a timely basis, with the exception of the February document. They did not reflect a thorough review or adequate follow-up to issues, however. For example: o The December Monthly Review noted in the comments that the QIDP	Noncompliance

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		was to review all SAPs and that they needed to be updated. At least two SAPs were noted to have met criteria. The January Monthly Review noted in the comments that the SAPs were reviewed with no recommendations at the time, but the document still indicated in the Action Plan review that these same two SAPs that had been identified as having met criteria in December continued to have met criteria and needed review; a third SAP had also reached that status. No actions taken in response were documented. The February Monthly Review stated new SAPs were implemented at the ISP; there was no narrative that would have demonstrated any continuity around skills training. o The February Monthly Review indicated the individual had been placed on 1:1 supervision on 2/22/14 until the IDT could meet. It did not provide any details as to the reason for this level of supervision. Even though the February Monthly Review was not completed until 4/1/14, it did not provide any indication of follow-up or resolution to this issue. No ISPA was provided documenting IDT review of this matter. o The Individual was rated as being at low risk for Behavioral Health at the ISP on 2/27/14, even though he was on a regimen of psychotropic medication, based on low rates of behaviors. It was not clear that the IDT had adequately assessed the individual's status in this regard, as the three Monthly Reviews documented five peer to peer interactions, with at least two resulting in injury to the individual. There was also concern about unauthorized departures, as described in the next bullet. Additional information from other sections of this Report was consistent with the above findings. • As reported in Provision O2, the QIDP monthly reviews, if completed, only stated if changes were made to the PNMP and provided no information regarding status of the individual or if the individual had any issues related to PNM. • As reported in Provision P2, a comprehensive progress note was completed by OT/PT on at least a monthly basis. However, these were not comprehensive as zero of four 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. o Contained information regarding whether the individual showed progress with the stated goal including clinical data to substantiate progress and/or lack of progress with the therapy goal(s). o Reported the consistency of implementation. o Identified recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress.	

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		• For individuals with PNMPs or SAPs focused on indirect services, there was no 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 QIDP 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 Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at 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 and had been found competent. 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. At the last visit, the Facility reported it had used the Q Construction Facilitation curriculum for training in this area and for evaluating competence and had conducted an annual competency recertification check during that review period, which would be within the past year. The Facility had implemented a QIDP Facilitator model in which one QIDP no longer carries a caseload but instead facilitates all ISP development; the individual currently in that role is the senior QIDP, who has been found competent as noted above. Staff responsible for implementing ISPs receive training using the Supporting Visions curriculum. The Self-Assessment reported that 95% of staff requiring this training since the last compliance visit had completed it. <u>Training on implementing ISPs</u> Training on foundational skills for new employees and in refresher training was consistently in place. For example, all new employees had completed the new employee orientation training on PNM core competencies, including the performance checkoffs. 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 three individual had received training on the latest revision to their PNMP. Two of three (67%) had evidence that staff were provided the needed training. As reported in Provision K12, there was little indication that the staff tasked with implementing PBSPs were adequately prepared to perform that task. The Facility did not present documentation	Noncompliance

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		• That certain PBSPs had been identified as requiring competency based training (CBT) 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. • As reported in Provision R3, the Monitoring Team reviewed evidence that all assigned staff for two individuals had received training related to Communication SAPs and programs. One of two (50%) individual's staff assigned had completed competency check-offs regarding the individuals' communication programs. Not all staff for Individual #84 were provided with the necessary training. To ensure staff receive training as needed, the Facility needs to carry out monitoring of treatment integrity. That has not yet been fully implemented. • 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 has taken steps to ensure staff responsible for developing and implementing ISPs receive competency-based training. Implementation should continue and expand.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	<u>Extent to which ISPs are revised annually and as needed:</u> The Facility provided a list of each individual at the Facility, with the most recent ISP meeting date, the date on which the ISP document was completed/filed, and the date of the previous ISP meeting date. The list also reported whether implementation of the ISP was timely. The column for date completed/filed was headed "Implementation Date"; there was no indication whether this meant something different from "Completed/Filed." The table documented that 67 of 67 individuals (100#) had an ISP meeting within 365 days following the last ISP meeting or had been admitted during that time. The table documented that seven ISP meetings had been held less than 30 days before the table was compiled, and the ISPs were not yet due. Of the remaining 60 ISP meetings, 34 ISPs (57%) were reported to have been received within 30 days. This table did not report whether ISPs had been implemented, that is, whether the action plans had been put into place; because many actions were continued, some may have been implemented more quickly, and others may not have actually started immediately. The table was alphabetical, and the Monitoring Team did not review to determine whether timeliness had improved during the current review period. Review of ISPs for Individuals #82 and #94 found that the ISP for Individual #94 had not	Noncompliance

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		been implemented on a timely basis, as the Action Plan section of the ISP held on 3/27/14 was not yet completed by the time the monitoring visit concluded. In addition, the SAPs provided for review were all dated prior to the ISP annual planning meeting and did not consistently reflect the changes recommended in the ISP. For example, the IDT agreed to discontinue a dining SAP for alternating liquids and solids and start a SAP for eating slower when cued. The only dining SAP provided for review was the former plan that was dated 11/05/2013. <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, three of three (100%) had an ISP meeting within 30 days of admission. For Individual #7, who was admitted too recently to be on the list, the ISP meeting was also within 30 days of admission. DADS policy required admission assessments to be completed at least five working days prior to the Admission ISP planning meeting. The Monitoring Team compared the date of admission ISP to the dates of assessments reported on the Assessment Report for Individuals #62 and #103 (the Assessment Report was not available for Individual #38) and to the assessments provided with the IEP packet for Individual #7. 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 four individuals, percent of assessments completed timely was 81% for Individual #7, and 13% for both Individuals #62 and #103. Percent of assessments completed by the date of the ISP meeting was 80% for Individual #7, 40% for Individual #62, and 60% for Individual #103.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The parties agreed the Monitoring Team would conduct reduced monitoring of this provision, because the Facility reported it had made limited progress. The noncompliance finding from the last review stands. The Facility used the Settlement Agreement Section F Monitoring Instrument to review ISPs. This tool assesses, among other aspects of the ISP, the facilitation and participation of the IDT; whether assessments are conducted; whether ISP elements address preferences, needs, and strengths, identifies needed supports, and encourages community participation; whether the ISP includes individualizes and measurable goals/objectives based on prioritized needs and preferences and identifies treatments and supports, including methods, timeframes, and responsibilities; establishes data collection procedures; whether the IDT meets if there is a significant change in the individual's status; whether staff receive competency based training on the ISP and the ISP process, including when plans are revised; and whether the ISP is updated and	Noncompliance

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		implemented timely. Each item is marked 1(Yes-10 points), 2 (Partial-5 points), 3 (No-0 points), or Not Applicable, and a percentage of available points is calculated. The Facility provided nine monitoring tools completed by George Romero (QIDP Manager) and nine completed by Rosa Sanchez (Quality Assurance). Seven of these assessed ISPs for the same individuals. Two differed, making a total of 11 ISP reviews provided. The Monitoring Team reviewed the tools provided by both reviewers for Individual #94, whose ISP was also reviewed by the Monitoring Team. The Monitoring Team calculated interobserver reliability for the two reviewers; agreement item-by-item was 92%. This high level of agreement indicates that the ratings are defined well enough to permit different raters to agree. The Monitoring Team review, although occurring at a very different time and not covering all aspects of the monitoring tool, provided additional support. The Monitoring Team found that timeframes for action plans were not identified; both raters had marked "3" indicating time frames were not documented. One item of disagreement between the Monitoring Team and the ISP reviewers was that the documents provided to the Monitoring Team did not identify who was responsible for actions, but the reviewers rated those as "1" indicating those responsible were identified. Further, as noted in the next paragraph, the Monitoring Team would not have rated integration of all protections, services, supports, and treatment plans as fully done, as both Facility reviewers did. Nonetheless, the consistent use of this tool provides information that may be useful, particularly if the criteria for rating some items are revised to address issues identified throughout this Section of the report and other issues raised throughout the report. There were also findings that indicated that this tool does not, by itself, cover all requirements of Section F or of ISPs that meet current, generally accepted standards. For example, for Individual #94, although (as rated by Facility reviewers) the ISP included action plans for the individual to have hair and nails done and to shop for clothes in the community (some of the individual's preferred activities), there was no indication these would be integrated with a separate money management SAP as a way of using preferences and strengths to build community living skills. Also, as reported in Provision F2a2, based on a small sample of two ISPs reviewed, it appeared the ISPs being developed did not included a full complement of individualized goals or objectives and/or strategies to address the array of supports and services the individual required. The monitoring tool did not specific ask whether goals and strategies address all the supports and services an individual needs. The tool does require an explanation for any need or barrier not addressed; both reviewers rated this "1" for Individual #94, which is inconsistent with the Monitoring Team's finding.	

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		Thus, although the tool provides a great deal of information about whether requirements of the Section are being met, it needs to be supplemented with a careful review of the quality of assessments and actions.	

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 5/7/14 2. RGSC Action Plans 5/7/14 3. Provision Action Information for Section G 4. Presentation Book Section G 5. DADS Policy 009.2 Medical Care 6. DADS Policy 004.2: Individual Support Plan Process 11/21/2013 7. RGSC SOP 400 19 Minimum Common Elements of Care 1/21/14, reviewed March 2014 8. RGSC Standard Operating Procedure (SOP) ICF-IID 600-01 Individual Support Plan Process (August 2012) 9. RGSC SOP IFC-IID 100 16, Morning Medical Report, Revised: March 2014 10. RGSC Standard Operating Procedure ICF-IID 400 14; Medical Care, dated November 2004, revised July 2013 11. RGSC SOP ICF-IID 400 17 Consultation Request Process 1/30/13 12. RGSC Daily Morning Medical Report meeting minutes for 4/14/14 through 4/17/14, 5/19/14-5/23/14, and the first Monday of each month November 2013 through April 2014 13. Examples of medical morning report meetings that include referral to IDT and follow up on referrals—Facility responded "None" **People Interviewed:** 1. David Moron, M.D., Clinical Director, Juan Miguel Gonzales, Program Improvement Manager, Rosa Sanchez, and Lorraine Hinrichs, IID Program Director **Meeting Attended/Observations:** 1. Morning Medical Report meetings 5/20/14, 5/21/14, and 5/23/14 2. ISP Annual Planning Meetings for Individuals #126 and #140 3. Admission ISP meeting for Individual #7 4. ISP Preparation meeting for Individual #85 5. Quarterly Psychiatric Review for Individual #51
	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 report use of monitoring/auditing tools. However, it is possible that tools were used. For example, the Self-Assessment reported the Nursing department audited QDRRs; it is possible an audit tool was used, but that was not stated

	• Used other relevant data sources and/or key indicators/outcome measures. Data included:
	  o Attendance at ISP meetings
	  o Percent of assessments posted on the shared drive 10 working days prior to IDT meetings (apparently, the annual ISP meetings)
	  o Percent of a sample of ISPs:
	  ▪ ISPs reflect that recommendations are addressed
	  ▪ Assessments were using to develop action plans
	  ▪ Included all necessary supports to meet the needs of the individuals
	  ▪ Showed integration of services provided to the individual
	  ▪ Showed collaboration between and participation of multiple disciplines in providing services and supports
	  o Report of improvement in Morning Medical Meeting minutes (but no information on the improvements was provided)
	  o Audits of Quarterly Drug Regimen Reviews (QDRRs) to determine whether Pharmacist and medical provider discussed findings and recommendations.
	  o Number of consultations reviewed by medical provider
	  o Number of consultations reviewed by the psychiatrist when a neurological consult was received
	• The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment:
	  o For the most part, presented findings consistently based on specific, measurable indicators. However, there was no indication of the criteria or definitions the raters used for many of the ratings (such as whether ISPs used assessments to develop action plans, whether there was collaboration among disciplines in providing services and supports, and whether the minutes of the Morning Medical Meeting had improved), and the ratings were not fully consistent with related findings throughout this report.
	  o Did not present data on reliability of measurement that would indicate the adequacy and clarity of the criteria or definitions used.
	  o For most measures, identified who collected the information.
	• The Facility rated itself as being in compliance with neither the following provisions of Section G. This was not consistent with the findings of the Monitoring Team, which rated Provision G2 as in compliance. The Facility rated noncompliance because of the lack of data on closure of consultations by the IDT. While the Monitoring Team agreed that this was needed and that there was little documentation of IDT review and action on recommendations by consulting clinicians, the Monitoring Team has determined since the last compliance visit that this is not a criterion for compliance with this provision, and that percentage of consultations reviewed and decisions on recommendations documented had increased above a 90% criterion level; therefore this provision is rated in substantial 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 In Process or Not Started

	• The Facility data identified areas of need/improvement. These included attendance at ISP meetings, timely completion of assessments, and closure by the IDT when a recommendation is made at Morning Medical Report Meeting to schedule an ISPA (Individual Support Plan Addendum meeting). It should be noted that integrated clinical services require much more than attendance at meetings and completing assessments. The Facility may review the report for Provision G1 to identify other integrative actions to be taken and monitored. • Although several actions were listed that should lead the Facility toward compliance, the actions as a whole did not provide a set of steps likely to lead to compliance with the requirements of this Section. That is, in part, due to the need to identify other aspects of integrated clinical services that need to be addressed. It is also due, in part, to a need to extend beyond the actions in place to further steps that address issues raised in this report. For example, it is appropriate to review strategies for improving integration. Once that review is completed, further action is needed to ensure the strategies are implemented and are effective. Methods to gauge quality and not just presence should be investigated and integrated as part of the Action Plan. The Facility should define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: The Facility implemented a policy on Minimum Common Elements of Care that addresses several aspects of clinical care and many of the requirements of Sections G and H. There are many examples of integrated and coordinated clinical services but also examples in which integration needs to be improved. **Provision G1:** The new policy on Minimum Common Elements of Care provides useful guidance. The Facility may wish to provide additional guidance on what constitutes integrated clinical services to make clear the broad range of opportunities and needs for integrated and collaborative services. The Facility encouraged integrated planning through the ISP process (as reported in Section F), and through several integrated committees and workgroups that addressed both individual care and systemic issues. The Morning Medical Report meeting, which provides a forum for integrated discussion, could be improved; the meeting communicated information but did not provided meaningful clinical review, did not function in an interdisciplinary manner, and did not demonstrate follow-up to previous reported issues. **Provision G2:** Facility clinicians documented review of recommendations by consultants and acceptance of consultant reports. They consistently completed integrated progress notes. Minutes of the Medical Morning Meetings documented report of consultation findings and additional actions planned by medical providers. Some or all QIDPs were present at each such meeting. This provided a process for notice to the IDT. One way to ensure the IDT then took appropriate action would be for the medical provider to state the cases in which the IDT should report back on decisions or actions related to consultation recommendations, and then to ensure the reports occur and are documented.

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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.	Policy The Facility had established and implemented a new policy that addressed the requirements of this provision. RGSC SOP 400 19 Minimum Common Elements of Care addresses several aspects of clinical care and many of the requirements of Sections G and H of the Settlement Agreement. Sections of the policy are: 1. Assessment and evaluation 2. Diagnoses 3. Treatments and interventions 4. Clinical indicators 5. System to monitor the health status of the individual 6. Treatments and interventions modified in response to clinical indicators 7. Integrated clinical services policies, procedures and guidelines The section on Assessment provides guidance for both scheduled assessments and "interval" assessments. The policy brings together timeframes for required scheduled reports for various clinical disciplines. "Interval" assessments occur in response to a Change of Status (CoS); this policy lists when post hospitalization assessments are required (for example, Nursing Assessment within two hours of arrival of the individual post discharge from the hospital, and Physical Nutritional Management Team within 72 hours of hospital discharge) and requires timely assessments following serious injury and in response to a CoS. The Facility should ensure all timeframes match requirements of other policies; while this seems generally to be the case, certain admission assessments either do not give a timeframe or require assessments to be completed within 30 days of admission, whereas DADS and Facility policy require assessments to be completed at least five working days prior to the admission ISP meeting. The timeline for annual discipline assessments is provided under the policy section that guides a system to monitor health status; it requires disciplines to "place their most current assessments in the integrated team folder 10 days prior to the Annual ISP." Policy, however, requires this to be done 10 working days prior. The policy provides useful guidance. The Facility may wish to provide additional guidance on what constitutes integrated clinical services to make clear the broad range of opportunities and needs for integrated and collaborative services. The policy relies strictly on ISP meetings and morning medical meetings. These meetings (especially the ISP meetings) are the central locus of integrated planning. However, participation in these meetings is not the only measure of integration. Other indicators of integrated planning include the degree to which multiple disciplines contribute to a specific outcome for an individual, the degree to which differences in recommendations and contradictory findings in assessments across disciplines are resolved, and the	Noncompliance

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		consistency of interventions developed by one discipline with information from assessments by other disciplines (for example, whether prompts in skill acquisition plans are consistent with communication recommendations from speech and language). The Facility encouraged integrated planning through the ISP process (as reported in Section F), and through several integrated committees and workgroups that addressed both individual care and systemic issues. <u>Morning Medical Report Meeting</u> RGSC continued to conduct a daily Morning Medical meeting five days per week. Participants include medical providers, unit nursing staff, and representatives from various departments, including Medical Providers, Nursing Services, Infection Control Preventionist, Habilitation Services, Behavioral Health Services, Psychiatry, Dietary Services, Residential Services, and Qualified Intellectual Disability Professionals (QIDPs). The purposes of the meeting are to discuss clinical issues affecting individuals to ensure continuity of care, and to enhance clinical management of individuals. The reports were driven by a specific agenda to review all changes in health care status of individuals over the past 24 hours as well as those occurring over the weekends and holidays. 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, infectious disease issues, and significant medical conditions. The Monitoring Team reviewed meeting minutes for the Morning Medical Report meetings that occurred on the first Monday of each month, beginning 11/2013 through 4/2014, for 4/14/14 through 4/17/14, and for 5/19/14 through 5/23/14. These minutes indicated very limited incidences reported by the living areas. One example was found in the minutes of 5/20/14 that reported on an issue with a feeding pump and the Individual's ISP meeting. In many cases, actions for follow up were established, but there was little indication that specific staff members were assigned responsibility to follow-up on clinical issues reported, and specific follow-up dates were not listed. There was some improvement in identifying and assigning follow up found in the minutes of 5/19/14 through 5/23/14. An example of follow up assigned was from the 5/23/14 minutes which stated "Action: UNM please report when magnets arrive and are labeled." This identified who was responsible and what the follow-up action would be. The next item also stated an action, "Action: Report statue (sic) of diabetic shoes." This did not indicate who was responsible for carrying out the action. The Monitoring Team noted these same findings at the last compliance visit, and the same issues were documented on the last report. Follow up by the IDT was not often listed as an action. Minutes of the meeting of 5/20/14 had actions for three individuals for the QIDP to report recommendations, ISP	

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		recommendations, or ISPA recommendations. There was no documentation of any reports for these individuals through 5/23/14. The Monitoring Team attended the morning medical meeting on Wednesday, 5/21/2014. The meeting demonstrated a full complement of disciplines, including physician, nursing, PT/OT, psychology, and habilitation staff. Observation showed some continued improvement over time in the integrated participation by representative disciplines. However, the Clinic Nurse presenting the reports read the information and rarely paused sufficiently to engage the participants in meaningful interdisciplinary interactions, nor was there sufficient discussion on clinical issues that should require follow-up actions. The Monitoring Team did not observe assertive interdisciplinary interaction when discussing clinical cases, and in general, the meeting functioned more like a report of what transpired on the previous day. For example: 1. An individual was reported to have sustained a fractured tooth, and there was no discussion about how the tooth was fractured, what may have precipitated the fractured tooth, and determination if additional supports and services were necessary. 2. It was reported that an Individual had refused medication, and there was no discussion to determine if the medication had eventually been administered, the reason for the medication refusal, and what, if any supports may be needed to assist the Individual in taking medication. 3. An Individual, who is known to have significant medical issues, was reported to have fallen on the floor, and there was no discussion to determine if a medical assessment had been completed to help rule out possible injury. Neither the minutes reviewed nor the meetings observed provided evidence of referrals to the IDT for review and action, nor of reports of follow up. In response to a document request for examples of morning report meetings that include referral to the IDT and follow up, the Facility responded, "None." As per the last compliance review by the Monitoring Team, it was determined that the morning medical meeting communicated information but did not provided meaningful clinical review, did not function in an interdisciplinary manner, and did not demonstrate follow-up to previous reported issues. This meeting, which did provide information to multiple disciplines, also had the potential to improve integrated services to individuals and to address systemic issues. The Facility should identify means to use the meeting more effectively. <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	

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		in status was through participation by the PNMT lead and PNMT RN in the morning medical meeting. Information from this meeting was then brought to weekly PNMT meeting for further discussion and shared with the IDT as indicated if not already done so. There was evidence of referrals to the PNMT when an individual experienced a change in status that would indicate such a referral. 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 PNMT also reviewed issues of skin integrity. The psychotropic polypharmacy work group provided an opportunity for integrated discussion of individuals prescribed polypharmacy and of systemic issues. The psychiatrist, chief executive nurse, and BCBA participated regularly, but documentation did not indicate that the pharmacist participated regularly. <u>Integrated Planning and Services for Individuals</u> Integrated planning requires disciplines to work together and coordinate activity to achieve ISP goals, objectives, anticipated outcomes, services, supports, and treatments. Examples of integrated planning may be found in several Sections of this report. • In ten out of ten examples (100%), quarterly psychiatric medication reviews and annual psychiatric assessments were completed as a part of the IDT; the psychiatrist, nurse, psychologist, the direct care support staff, and the QIDP 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 quarterly psychiatric medication review by phone. • As reported in Provision P2, in eight of eight of the ISPs or ISPAs reviewed (100%), skill acquisition programs or opportunities for skill acquisition that had been recommended in the OT/PT assessment were present. • Collaboration between Speech and Language and BCBAs appeared to be working well. Communication strategies identified in communication assessments were included in PBSPs and ISPs. • As reported in Provision R3, Communication Dictionaries for seven of seven 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. There were also examples of a lack of integrated planning. • Regarding Individual #126, on 4/9/2014, the BCBA was notified to evaluate the Individual to assess for maladaptive behaviors when transferring. The BCBA reported that the behaviors were most probably associated with an underlying	

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		medical condition, and recommended that a medical evaluation be provided. Upon review of the active record, review of medical provider's IPNs, and discussion with the BCBA, the Monitoring Team found no evidence to indicate that a medical assessment was done to evaluate for underlying medical causes resulting in maladaptive behaviors. Furthermore, although this individual had multiple medical issues including GERD and bowel issues, there was no evidence of active participation by the physician as part of the PNMT process. • As reported in Section O, there was a lack of evidence of indicators being integrated as part of the Integrated Health Care Plans (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). • Individual #46 had periodontal disease and lost a tooth with no sign of trauma. On 3/21/2014 a modified barium swallow study was completed and the Individual was noted to have had aspiration of food secondary to poor mastication, and no further work-up was documented; ultimately, the Individual was started on modified diet. There was no documentation that dental clinicians, nurses, and the PNMT or other habilitation therapists assessed the possibility that the individual's oral condition and possible pain may have contributed to the poor mastication and the need for a modified diet, even following a swallow study that identified aspiration secondary to poor mastication. This was a missed opportunity for clinical integration that might improve the individual's ability to eat safely without restrictions, as well as possibly to reduce pain. <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 of IDT members when required was high. The only exception was physicians, for whom improvement is needed. 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. Observation found examples of interdisciplinary planning and integration of clinical services for individuals, including: 1. At the quarterly psychiatric treatment review for Individual #51, the QIDP, psychiatrist, RN Case Manager, Dietitian, psychology assistant, and direct support professional (DSP) participated. All staff participated actively. The psychiatrist did	

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		an excellent job of gathering information from each participant. The intervention to decrease refusals to go to medical appointments was revised to use a yogurt drink as a reinforcer. This is is a favored treat but also may help address the individual's gastritis. This selection of a reinforcer demonstrated integrated clinical planning to ensure an intervention was consistent with, and made use of, information from assessments by multiple disciplines. 2. At the annual ISP meeting for Individual #140, there was excellent integrated discussion among the QIDP, speech-language pathologist (SLP), psychiatrist, transition specialist, and local authority (LA) about concerns the individual's father had about considering movement to a more integrated setting. There was also integrated discussion about the individual's falling, including a decision that the behavior analyst would retrain staff on the behavior support plan. Although in general there was good interaction across team members, some observations indicated a lack of integrated planning. 3. Although most IDT members participated actively in the annual ISP planning meeting for Individual #126, the discussion did not necessarily produce outcomes indicative of integrated clinical planning. There was extended discussion of whether the individual had an instance of pneumonia. The physician reported the signs that would indicate pneumonia, but some members of the IDT focused on facility guidelines for diagnosis and did not consider the physician's information. The individual, as noted above, exhibited problematic behaviors that might have been related to a medical condition, but this was not discussed. See Provision L1 for detailed information. 4. As reported in Provision M5, IHCPs were not sufficiently integrated among all relevant disciplines. As reported in Provision O2, recommendations by the PNMT were not clearly integrated into Integrated Health Care Plans (IHCPs). 5. As reported in Provision R3, ISPs did not include how communication interventions were to be integrated into the individual's daily routine. As examples above indicate, there is more to integration than reporting status, completing assessments timely, and having integrated workgroups (all of which are necessary for integrated services but not sufficient). To achieve substantial compliance, the Facility needs to continue to help staff identify inconsistencies among assessments and related services, to improve the consideration of how risks in one area of functioning and health may affect other areas and the services needed, and remind clinicians that they need to communicate with other disciplines when they identify changes in an individual's status.	
G2	Commencing within six months of	<u>Policy</u>	Substantial

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	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.	DADS Policy 009.2 Medical Care describes the responsibility of the attending primary care physician (PCP) to write initial consultation referrals and states "Routine medical/surgical consultation recommendations are addressed within five working days of receiving the consultation" and requires that there must be a clear explanation in the IPN if recommendations are not implemented. It also identifies IDT responsibilities to document implementation of recommendations. 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, that a copy of the consult form be provided to the QIDP and reviewed by the IDT, and that the PCP or designee shares the consultation recommendations with the IDT, when applicable. RGSC SOP ICF-IID 400 17 Consultation Request Process guided 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 comprehensive policy covers the major issues of consultation. The report of the last compliance visit described this policy in greater detail. <u>Review of Consultations by Facility Clinicians</u> The Facility used the RGSC Referral/Consultation Report form that included the name of the consultant, date and time of appointment, reason for the consultation, name of physician and nurse manager, requested date/time, consultant findings and recommendations, RGSC physician date/time of review, and whether the medical provider accepted the consultant recommendations or did not accept them (with requirement the medical provider must provide rationale for not accepting). The Monitoring Team reviewed a sample of 12 medical consultation reports for nine Individuals #28 (X2), #29 (X2), #35, #48, #60 (X2), #65, #84, #103, and #127, and four Modified Barium Swallow Studies (MBSS) for Individuals #3, #46, #94, and #103. • For the medical consultations: o Twelve of twelve (100%) had evidence of review by a PCP. ▪ Twelve of twelve (100%) had evidence on the consultation form of review by a PCP (initials and date). Twelve (100%) had a progress note in the Integrated Progress Note (IPN) section of the Active Record. Of those twelve, the IPNs were completed within five business days for 12 (100%). ▪ Twelve (100%) documented acceptance of the recommendations either on the form or in an IPN; all were	Compliance

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		accepted, and none had documentation of rejection. • For the MBSS consultations: o Four of four (100%) documented review with a note on the consultation report and/or progress note in the IPN. Four (100%) had IPNs; of those, four (100% of total) were completed within five business days. o Four of four (100%) documented acceptance of the recommendations. • Overall: o Sixteen of 16 (100%) documented review by a Facility clinician, through either a notation on the consultation report or an IPN, or both. o Sixteen of 16 (100%) documented acceptance of recommendations. An additional issue involved dentistry. The Facility did not employ a dentist, and dental services were provided by appointment with community dentists. At the last compliance visit, the Monitoring Team reported the consultation report form was usually provided; in all cases, the physician agreed with the dentist's recommendation. This finding is consistent with findings at this visit for medical and MBSS consultations. Minutes of the Medical Morning Meetings documented report of consultation findings and additional actions planned by medical providers. Some or all QIDPs were present at each such meeting. This provided a process for notice to the IDT. One way to ensure the IDT then took appropriate action would be for the medical provider to state the cases in which the IDT should report back on decisions or actions related to consultation recommendations, and then to ensure the reports occur and are documented. The Facility reported that two new categories will be added to the consultation audit—referral to the IDT and follow up by the IDT. That was expected to begin with upcoming May audits. These findings indicate the Facility was in substantial compliance with requirements of this provision. One example points out the need to ensure that the response by the medical provider is thorough and leads to action as needed. The example of Individual #46 reported in Provision G1 provides one example in which review by a Facility clinician should have led to review by additional clinicians; the process to do this could have been through referral to the IDT. The Monitoring Team did not review to determine whether the Facility clinician had reviewed this consultation or any recommendations, or had referred this. The lack of IDT consideration of the possible contribution of the individual's dental condition to aspiration and the need for a modified diet would indicate that such referral either did not occur or did not lead to action.	

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 5/7/14 2. RGSC Action Plans 5/7/14 3. Provision Action Information for Section H 4. Presentation Book Section H 5. DADS Policy 004.2: Individual Support Plan Process 11/21/2013 6. RGSC SOP 400 19 Minimum Common Elements of Care 1/21/14, reviewed March 2014 7. RGSC Standard Operating Procedure (SOP) ICF-IID 600-01 Individual Support Plan Process (August 2012) 8. RGSC SOP 400 19 Minimum Common Elements of Care 1/21/14 9. All admission assessments for Individual #7 10. RGSC Daily Morning Medical Report meeting minutes for 4/14/14 through 4/17/14, 5/19/14-5/23/14, and the first Monday of each month November 2013 through April 2014 11. Integrated support plans and associated assessments for Individuals #82 and #94 12. ISP Assessments Tracking Log November 2013 through March 2014 13. Settlement Agreement-Program Improvement Council (SA-PIC) minutes of 4/10/14 14. RGSC Quality Assurance Matrix-Revised 4/11/14 **People Interviewed:** 1. David Moron, M.D., Clinical Director, Juan Miguel Gonzales, Program Improvement Manager, Rosa Sanchez, and Lorraine Hinrichs, IID Program Director **Meeting Attended/Observations:** 1. ISP Annual Planning Meetings for Individuals #126 and #140 2. Admission ISP meeting for Individual #7 3. ISP Preparation meeting for Individual #85 4. Quarterly Psychiatric Review for Individual #51 5. Morning Medical Report meetings 5/20/14, 5/21/14, and 5/23/14
	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: o The monitoring/audit tools the Facility used to conduct its self-assessment included: ▪ Medical Provider Audits for Round 8 ▪ Section I At-Risk monitoring tool

	▪ Another audit was listed in Provision H1, but there was no indication of what was audited or what audit tool was used. There was simply a list of months and columns for # records audited, # out of compliance, and % of compliance. A sentence below mentioned the MOSES/DISCUS. o It was unclear whether monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. Overall percentages of compliance were provided for both the Medical Provider Audits and the Section I tool. There was no way to determine whether the Facility identified and assessed specific items relevant to specific provision requirements; that did not appear to be the case, as the same percentages were provided in assessing both Provision H1 and Provision H3. Similarly, it was unclear whether these monitoring tools included adequate methodologies to assess the specific requirements of the provisions. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The Self-Assessment identified the sample size for use of the Section I tool but did not identify the sample sizes for the Medical Provider Audits. This sample size for the Section I monitoring tool was small (four records); the Monitoring Team could not determine if this was adequate to consider it a representative sample. o The Self-Assessment did not identify staff/positions were responsible for completing the audit tools. o Adequate inter-rater reliability was not reported between the various Facility staff responsible for the completion of the tools. • Used other relevant data sources and/or key indicators/outcome. Data included: o Whether active problem lists (APLs) were available, current, and had updated and current diagnoses. No data were provided. o Timeliness of assessments o Numbers of acute care plans (ACPs) o Numbers of individuals underweight or overweight o Hg A1c data and number of individuals with diabetes o Diagnoses of pneumonia o Number of hospital admissions • The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Did present data to support the assessment of improvement in APLs o Did not measure the quality as well as presence of items. o For many items, did not relate the information reported to the requirements of the provision. While the outcome data were important, they either did not address the requirements or they were only a small set of examples relevant to the requirement. Data on timeliness of assessments was reported in Provision H3 (which is about timeliness of treatments and interventions and clinical appropriateness based on assessments and diagnoses) but not in Provision H1, which requires assessments to be performed on a regular basis.

	• The Facility rated itself as being in compliance with Provision H2. This was consistent with the Monitoring Team's findings as the parties had determined that the substantial compliance rating for Provision H2 would be continued without monitoring due to history of 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 or In Process. Several items reported as In Process were actually continuations of ongoing processes with no indication of further improvement actions or initiatives to be taken as a result. These included presenting Medical Provider Audit data to Facility administrators, continuing QIDP/Nurse Case Manager Peer Support meetings, and monitoring a medical record each month using the Section I rating tool and then providing training to the IDT. • The Facility data identified areas of need/improvement. These included changes in plans not occurring consistently when a significant change in health status occurs, need to create additional clinical indicators and expectations, and lack of updates to Integrated Health Care Plans (IHCPs) documented as needed. There was an action plan for ongoing meetings with physicians to develop monitoring parameters for seven medical conditions. The action plans to monitor one medical record per month using the Section I rating tool include determining whether interventions correlate to changes in the individual's health status. • 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. For example, there were no plans for actions related to ensuring interventions are reviewed and, as needed, revised when there is a change in an individual's health status other then reviewing one record per month and providing training; ensuring this occurs requires further actions.
	Summary of Monitor's Assessment: Progress on this Section was limited since the last compliance visit. The most evident area of progress was in the development of a policy to address the requirements, which now needs to be operationalized and implemented accurately. **Provision H1:** The Facility had established and implemented a new policy that addressed the requirements of this provision. This policy is comprehensive in regard to the requirements of Section H. As noted in the findings of this visit for Section H, Section F, and others, the policy had not yet been fully operationalized and implemented. Overall, improvement is still needed in completing routine assessments. Assessments for the ISP were still not routinely completed on a timely basis. Comprehensiveness of assessments varied across disciplines. Some were generally consistent with requirements, others had most but not all required components, and others continued to miss important components. Assessments were conducted timely when the IDT identified a change of status for an individual.

	Provision H2: 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. **Provision H3:** The Facility did not have procedures in place to ensure or monitor that treatments and interventions were implemented timely. Timeliness of implementation of treatments and interventions was variable but improving. Examples were found of appropriate clinical treatment. There were also examples in which treatment could have been more assertive. **Provision H4:** The recently implemented policy requires the RGSC Clinical Director to develop guidelines and parameters for monitoring the status of health care conditions, as well as "clinical indicators that will measure the efficacy of the treatments and interventions for each of the nine Healthcare categories"--a positive finding. It also requires the Clinical Director and ICF Program Director to "develop tools to assess the delivery of care for the nine Healthcare Conditions." There remained a need to meet these requirements. 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/or systemic review of the common and serious chronic health conditions found in the individuals served at the Facility. **Provision H5:** The Facility had not made progress on establishing a system to monitor the health status of individuals. 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. Although there was some structured use of objective indicators to assess effects of treatments and interventions, this was not consistent across all clinical areas. **Provision H6:** Although the Facility now had clear guidance in policy on the use of clinical indicators, operationalization of this guidance was not yet fully in place. Clinical indicators had not been established for all areas required by policy, and the Facility did not provide clinical pathways to show that there were requirements for regular documentation of specific clinical indicators for common and/or serious conditions. There were examples in which treatments and interventions were modified in response to clinical indicators, but this was not consistent across all areas. **Provision H7:** The Facility had established and implemented a new policy that addressed the requirements of this provision. This policy is comprehensive in regard to the requirements of Section H. The policy had not yet been fully operationalized and implemented. Nonetheless, the Monitoring Team compliments the Facility on moving forward with developing this policy.

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H1	Commencing within six months of the Effective Date hereof and with	<u>Policy</u> DADS Policy 004.2 continued the requirement that IDT members complete required	Noncompliance

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	full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	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. The Facility had established and implemented a new policy that addressed the requirements of this provision. RGSC SOP 400 19 Minimum Common Elements of Care addresses several aspects of clinical care and many of the requirements of Sections G and H of the Settlement Agreement. Sections of the policy are: 1. Assessment and evaluation 2. Diagnoses 3. Treatments and interventions 4. Clinical indicators 5. System to monitor the health status of the individual 6. Treatments and interventions modified in response to clinical indicators 7. Integrated clinical services policies, procedures and guidelines The section of this on Assessment provides guidance for both scheduled assessments and "interval" assessments. A detailed discussion of this policy is found in Provision G1. The policy brings together timeframes for required scheduled reports for various clinical disciplines. "Interval" assessments occur in response to a Change of Status (CoS). The Facility should check to ensure the timelines for assessments are consistent across all DADS and Facility policies. <u>Extent to which assessments are conducted routinely</u> 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 reviewed clearly defined the assessments that were to be completed. Overall, improvement is still needed in completing routine assessments. Assessments for the ISP were still not routinely completed on a timely basis. A sample of two recent ISPs found lack of completion of assessments in time to permit IDT review prior to the annual ISP planning meeting and in compliance with policy requirements. • 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 32 assessments that were required to be completed 10 working days prior to the ISP date, 18 (56%) were completed on a timely basis. This is consistent with the data provided in the monthly Assessment Reports	

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		table described below. The Facility provided monthly Assessment Reports tracking assessment completion for November 2013 through March 2014. 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 November and December 2013, and January, February, and March 2014 respectively, the percent of assessments completed timely was 50%, 53%, 36%, 58%, and 53%. This was, overall, a slight improvement compared to the findings at the last compliance visit. The Assessment Reports also reported the percent of assessments completed by the time the report was done (in the first week of the following month). This indicated many of the assessments were completed but had not been posted for IDT review 10 working days in advance of the ISP annual meeting. For ISP planning meetings held in November and December 2013, and January, February, and March 2014 respectively, the percent of assessments completed was 74%, 80%, 70%, 91%, and 80%. The range was greater than that found in the last compliance visit and was overall slightly lower for the current period. Completion of assessments was variable across disciplines. Some disciplines consistently completed assessments on time. For example: • Seven of eight individuals' OT/PT assessments reviewed (88%) were dated as having been completed at least 10 working days prior to the annual ISP. • According to the Assessments Report, nutritional assessments were consistently timely. Other examples indicated a need for improvement in completing annual and quarterly assessments and updates timely: • As reported in Provision K7, psychological assessments were not consistently completed annually. Furthermore, there was often not documentation of intellectual assessments within the prior five years or of annual adaptive assessments. • As reported in Provision M2, It was apparent through review of the Self-Assessment, interviews with Nursing Administration, and review of documents that concerted efforts had been made to improve the timeliness of the Annual/Quarterly Nursing Assessments. At this compliance review there was no appreciable improvement found with this Provision. One of two (50%) Annual Comprehensive Nursing Assessments in the reviewed sample that were due were completed on time, according to Facility policy. Two of three (67%)	

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		Quarterly Comprehensive Nursing Assessments due were completed on time, according to Facility policy. • For eight of 13 individuals in Samples R.1, R.2, R.3, and R.4) (62%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP However, seven of seven communication updates/assessments (100%) were completed consistent with the established schedule, or the individuals' need. It should be noted that 100% of the assessments completed post January 2014 were completed in a timely manner. • According to the Assessments Report, disciplines completing assessments timely for less than half the annual ISP meetings included medical, psychiatric, and psychological. • As reported in Section S, during the current visit, the Facility was asked to provide ISP documentation, as well as associated assessment reports and skill acquisition programs, for 10 individuals living at the Facility. Included in this request were Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. Three document requests were eventually submitted: one submitted on-site and two follow-up requests submitted following the site visit. As reflected in the table below, for no individual were more than 43% of the required assessment reports submitted. Furthermore, none of the 14 types of assessment reports (0%) was submitted for all individuals in the sample. On the other hand, there was improvement in completion of assessments when individuals were admitted. • For Individual #103, the Facility provided a list of assessments to be completed before the admission ISP meeting and of those completed as of 5/21/14. Only four of 15 assessments (27%) were dated at least five working days prior to the meeting. • The Monitoring Team reviewed all admission assessments for Individual #7; all were completed within 30 days of admission. Nine of 12 (75%) were completed at least five working days prior to the admission ISP meeting; one additional was undated, and two were completed the day of or day before the admission ISP meeting. • The report provided by the Facility did not report the Psychological Assessment for Individual #103 was completed, although, as noted in Provision K7, a tracking list reported the Behavioral Health Assessment had been completed within 30 days following the ISP meeting. The Behavior Health Assessments for the new admissions (#38, #62, and #103) were all dated within 30 days of admission per the assessment tracking information provided. • Four of four OT/PT assessments for newly admitted individuals (100%) were posted a minimum of five working days before the admission ISP meeting.	

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		• Four of four (100%) Admission Comprehensive Nursing Assessments were completed within 30 days of admission. All were completed at least five working days prior to the admission ISP meeting. The Facility has put into place actions intended to improve timeliness of assessments. The QIDP Facilitator model has been implemented, with one QIDP facilitating all annual ISP development. This provides one staff who focuses on getting the required documentation and facilitating the ISP planning meeting. Also, a reminder is now sent to psychiatrists 20 days prior to the ISP meeting. <u>Comprehensiveness of Scheduled Assessments</u> Comprehensiveness of assessments varied across disciplines. Some were generally consistent with requirements, others had most but not all required components, and others continued to miss important components. Furthermore, the Facility did not provide all assessments requested by the Monitoring Team. • As reported in Provision K7: o Structural and Functional Assessments (SFAs) were comprehensive and included all required behavioral components. They included some presentation of mental illness diagnoses and potential relationships between environmentally based behavior and symptoms of mental illness. However, the Facility did not provide all the requested sample of SFAs. The Monitoring Team could not determine whether the missing SFAs had been completed or were comprehensive. o 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. For the sample reviewed, nearly all assessments included documentation of intelligence testing within the prior five years, but a minority provided documentation of assessment of adaptive skills within the prior year. • As reported in Provision P1, some components of comprehensive OT/PT assessments were consistently present, but many components were not. Inclusion of comparison of status from year to year had shown improvement in the past but had declined since the new assessment format was implemented at RGSC. PT/OT assessments reviewed did not include specific measurements when assessing spasticity. • As reported in Provision R2, the speech assessment continued to show improvement but still needed to do a better job in providing better guidance into how strategies and recommendations should be integrated into the daily schedule. • Annual medical assessments did not always include all appropriate	

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		examinations.
		• For individuals with cerebral palsy, the Medical provider documented regular assessments for the potential manifestations of CP in zero out of five examples (0%).
		  o For individuals with osteoporosis, 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.
		• A review of the Admission, Annual, and Quarterly Nursing Assessments for timeliness, content, and quality found no appreciable improvement from the last compliance review. Findings included:
		  o Four of eight (50%) of the nursing assessments did not include the quarterly physical assessments that are required by the DADS Guidelines for Comprehensive nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment.
		
		For individuals who had been recently admitted:
		• Four of four newly admitted 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.
		• Behavioral Health Assessments had been completed.
		1. Two of four individuals (50%) had been provided an assessment of adaptive skills. Although the admission Behavioral Health Assessment for Individual #7 provided an Adaptive Behavior Level, it gave no information about specific adaptive behaviors or areas of strength and need.
		2. Four of four individuals (100%) had been provided an assessment of intellectual ability.
		3. Four of four individuals (100%) had assessments compiled and interpreted within a written assessment report.
		
		<u>Extent to which comprehensive assessments are conducted timely when there is a significant change of status for an individual</u>
		Assessments were conducted timely when the IDT identified a change of status for an individual.
		• As reported in Provision O2, the Physical and Nutritional Management Team (PNMT) initiated an assessment within five working days of a referral or sooner as specified in the PNMT policy.	

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		○ As reported in Provision L1, ten out of 11 acute medical conditions reviewed for a sample of individuals (91%) included a comprehensive and clinically appropriate initial assessment of the acute medical condition. Initial assessments by the medical provider were timely, clinically appropriate, and indicated the need for consultations and, or diagnostics, when clinically necessary.	
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.	Substantial Compliance
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	<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. Timeliness of implementation of treatments and interventions was variable but improving: ○ As reported in Provision O8, for two of two individuals whose plan for return to oral eating were determined to need revision, plans were modified by the IDT. For these individuals' plan (100%), the IDT met and interventions were reviewed and changed, as appropriate, in a timely manner. ○ As reported in Provision O3 for individuals for whom the IDT identified changes needed to be made to the PNMP, ISPA meeting documentation noted for ten of ten individuals (100%) that the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. As reported in Provision O2, in one of two individuals' documentation reviewed (50%), supporting documentation was present to confirm implementation of individuals' action plan within 14 days, or sooner as needed, of the plan's finalization. ○ For individuals receiving OT/PT supports and services, 10 of 12 plans for Samples P.1 and P.2 (83%) were developed within 30 days of the date of the assessment/update, or sooner as indicated by need. Three of 4 individuals' direct intervention plans (75%) were implemented within	Noncompliance

#	Provision	Assessment of Status	Compliance
		30 days of the plan's creation, or sooner as required by the individuals' health or safety. o As reported in Provision K9, review of Facility tracking data also reflected that RGSC experienced difficulty in implementing PBSPs promptly after approval and consent were obtained. For 42 of 58 active PBSPs (72%), there was a delay of greater than 14 days between consent and implementation. The average noted delay was 42 days. o As reported in Provision M5 for individuals for whom IDTs identified areas of high risk: o Only four of eight (50%) individuals' had IHCPs developed for the identified high risk ratings reviewed. o Three of four (75%) individuals' IHCPs indicated they were approved and implemented by the IDTs within 14 days. o As reported in Provision P2 for individuals receiving OT/PT supports and services, 10 of 12 plans for Samples P.1 and P.2 (83%) 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 appropriate treatment. There were also examples in which treatment could have been more assertive. o 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 five 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 five examples (0%). In no cases were deep tendon reflexes (DTRs) or range of motion reported to have been measured. o 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. 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	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>document that indicated that the etiology for underlying low bone mineral density was not evaluated.
o Five out of five examples (100%) included evidence that a clinically appropriate diagnostic was obtained to assess bone density and treatment efficacy, when clinically indicated.
• As reported in Provision L1, important health conditions were not addressed for Individual #126, there was no evidence pain was routinely assessed although the individual was at risk for significant pain and possible signs of pain existed (such as maladaptive behavior prior to bowel movements, a report by the BCBA that maladaptive behaviors were probably associated with an underlying medical condition, and diagnosis of GERD). As reported in Provision M1, there was no ICHP to accompany the individual's high risk rating for constipation/bowel obstruction.</td><td></td></tr>
<tr><td>H4</td><td>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.</td><td>The Facility had established a comprehensive policy that provided good guidance for the use of clinical indicators. At this point, the number of conditions for which clinical indicators for regular assessment for individuals had not expanded, nor was there evidence of consistent use and documentation of clinical indicators when treating individuals.

<u>Policy</u>
RGSC SOP 400 19 Minimum Common Elements of Care requires the RGSC Clinical Director to develop guidelines and parameters for monitoring the status of health care conditions, as well as "clinical indicators that will measure the efficacy of the treatments and interventions for each of the nine Healthcare categories"--a positive finding. It also requires the Clinical Director and ICF Program Director to "develop tools to assess the delivery of care for the nine Healthcare Conditions." Listed under a heading of "Ten Healthcare Conditions/Clinical Indicator Categories" are the following eight conditions and categories:
<table>
<tr><td>1. Diabetes:</td><td>American Diabetes Association guidelines for management of type 1 and type II Diabetes. Clinical Protocols/SSLC</td></tr>
<tr><td>2. Aspiration Pneumonia (Pneumonia):</td><td>Clinical Protocols/SSLC</td></tr>
<tr><td>3. Osteoporosis:</td><td>Clinical Protocols/SSLC</td></tr>
<tr><td>4. Urinary Tract Infection (UTI):</td><td>Clinical Protocols/SSLC Clinical Protocols/SSLC</td></tr>
<tr><td>5. Seizures:</td><td>Clinical Protocols/SSLC</td></tr>
</table></td><td>Noncompliance</td></tr>
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6. Constipation:	Clinical Protocols/SSLC
7. Metabolic Syndrome	Clinical Protocols/SSLC
8. GERD	
Other Guidelines	Listed in Standardized DADS Policies. National Guidelines Clearinghouse of the US Agency for Healthcare Quality and Research at www.guidelines.gov.

The policy also references the external and internal medical services audits and the requirement for corrective actions in response to the audits.

The policy requires RGSC to "establish and maintain a system to effectively monitor the health status of the individual. The ISP Process is the system that designates risk rating or health status rating for the nine Healthcare categories on the Integrated Risk Rating Form (IRRF)."

The policy further requires medical disciplines to "identify response to treatment and intervention through tracking, trending and analyzing the data obtained from utilizing the clinical indicators" and to "trend the needed intervention per facility, per individual, or other areas…"and to ensure treatments and interventions are modified as appropriate in response to clinical indicators.

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/or systemic review of the common and serious chronic health conditions found in the individuals served at the Facility.

This is a comprehensive policy that addresses many issues of development and use of clinical indicators.

In interview, the Facility listed several clinical indicators or ways in which clinicians use clinical indicators:

- Measurable data for behavioral programs
- Clinical indicators for referral to or discharge from Physical and Nutritional Management Team (PNMT) services
- Pharmacy and Therapeutics Committee (P&TC) reviews the numbers of individuals prescribed specific medications of concern, such as Mellaril and Clozaril.
- Assessments of mental health status such as the DASH and PIMRA are being

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		used; there is a plan to use them quarterly along with target symptoms. • Habilitation is using measures such as length of time someone walks or stands. • Health measures are being tracked, such as HgA1c for individuals with diabetes, body mass index (BMI), instances of pneumonia. For individuals at risk for metabolic disorder, the Facility reported tracking at quarterly psychiatric reviews of BMI, girth, blood pressure, and weight. The Self-Assessment for Section H provided data on the following: • BMI • A1c and number of diabetes cases • Pneumonia cases The Monitoring Team reviewed, in several Sections of this report, to determine whether clinical indicators are being used in compliance with the policy. • Since the last compliance visit, RGSC's PNMT has developed key indicators that were designed to identify if services were being provided that met the needs of the individuals. Some the areas included in these key indicators were: • Number of individuals whose risk level increased or decreased • Number of choking events caused by error. Reviews of the indicators were also scheduled to be included as part of the PNMT meeting. Discussion of the indicators had not yet occurred so this will be a process that will be reviewed during the next visit. Based on review of records for individuals who were referred to the PNMT, • 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. • Zero of two (0%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. • As reported in Provision O7, IHCP sections related to PNM did not contain evidence of clinical indicators to assess the individual's PNM status. Although the policy described in this provisions states that the ISP process is the system that identifies risk, the sample reviewed did not provide 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. QIDP 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.	

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		• As reported in Provision I1, the use of clinical indicators in establishing and documenting IRRFs was just beginning. The purpose of risk ratings is to identify areas of treatment and intervention that must be prioritized. The use of clinical indicators does not only assist in such identification, but also provides metrics to assess the effectiveness of the treatments and interventions for individuals so that ineffective treatments are not continued for extended times. The review of a sample of IHCPs reported in Provision M5 verified that clinical indicators were not consistently identified in IHCPs. IHCPs for individuals in the sample did not consistently include clinical indicators to be monitored. One example of an IHCP for which a clinical indicators was identified was for Individual #140. The individual had a history of diabetes; clinical indicators were for monthly fasting blood sugars and annual A1c. • Graphed data were used to assess progress of individuals regarding problematic behaviors and as one means to assess status of psychiatric conditions and effectiveness of treatment. • For individuals receiving direct OT or PT services whose records were reviewed (0%), there were no measurable objectives related to functional individual outcomes included in the ISP or ISPA.	
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 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: 1. Records of individuals with PNM difficulties did not contain evidence that their progress and status, and the effectiveness of their 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. QIDP 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. 2. Individuals' OT/PT assessments did not consistently offer a comparative analysis of	Noncompliance

#	Provision	Assessment of Status	Compliance
		current functional motor skills and ADLs with previous assessments. This was an area that was noted to decline since the last compliance visit. Measurement as it relates to individuals with potentially worsening conditions was not consistently provided. Although a comprehensive progress note was completed on at least a monthly basis, none of the notes reviewed 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). This was an area noted in previous reviews and has shown little improvement. For example: 3. The OT/PT Comprehensive Assessment Evaluation, updated 9/23/2013 for Individual #85, did not include range of motion measurements for this Individual, who has a diagnosis of cerebral palsy, and spasticity. There was some structured use of objective indicators to assess effects of treatments and interventions. 4. As reported in Provision K4, graphed data are reviewed by a BCBA monthly or more frequently if needed, such as due to use of restraints or changes in risk level. However, there is question as to whether the data collection are sufficient to assess progress, in part because staff were permitted to wait until the end of shift to record occurrence of target and replacement behaviors, which can lead to inaccuracy. 5. For individuals receiving direct speech services, recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. For PNM issues, the findings were mixed: 6. 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. 7. In zero of two individuals' plans reviewed (100%), the plans included the specific clinical indicators of health status to be monitored. Clinical indicators of health status were not detailed enough or were missing, resulting in a decreased ability of staff to ensure that changes in health status were noted by staff. For example, Individual #126's IHCP did not include information regarding what staff should be monitoring to ensure safety and effectiveness of plan. In regard to aggregating indicators to provide information on health status and on status of healthcare, the data listed in the Facility's Quality Assurance Matrix were mostly numbers of individuals diagnosed with specific conditions. This matrix did not include the indicators provided in the Self-Assessment, such as BMI and A1c. The Facility did not provide documentation of any other list of clinical indicators reviewed regularly to assess status of health and healthcare.	

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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.	Although the Facility now had clear guidance in policy on the use of clinical indicators, operationalization of this guidance was not yet fully in place. Clinical indicators had not been established for all areas required by policy, and the Facility did not provide clinical pathways to show that there were requirements for regular documentation of specific clinical indicators for common and/or serious conditions. Given the lack of report of clinical indicators, it was difficult to determine whether treatments and interventions were modified in response to changes in clinical information. Treatments and interventions were revised, especially in regard to acute health conditions. In addition: 8. Modifications to the PBSP reflect data-based decisions. Progress was evident, or program modified in timely manner (3 Months), for five of seven (71%) individuals whose treatment data were reviewed. Note, however, that documents requested for three additional individuals were not provided, so the Monitoring Team cannot assess the consistency with which revisions to PBSPs were made. There were examples in which changes did not consistently occur based on clinical indicators. o Monthly Reviews for December 2013, and for January and February 2014, for Individual #82, appeared to be generally completed on a timely basis, with the exception of the February document. They did not reflect a thorough review or adequate follow-up to issues, however. For example: o The December Monthly Review noted in the comments that the QIDP was to review all skill acquisition plans (SAPs) and that they needed to be updated. At least two SAPs were noted to have met criteria. The January Monthly Review noted in the comments that the SAPs were reviewed with no recommendations at the time, but the document still indicated in the Action Plan review that these same two SAPs that had been identified as having met criteria in December continued to have met criteria and needed review; a third SAP had also reached that status. No actions taken in response were documented. The February Monthly Review stated new SAPs were implemented at the ISP; there was no narrative that would have demonstrated any continuity around skills training.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish	The Facility had established and implemented a new policy that addressed the requirements of this provision, RGSC SOP 400 19 Minimum Common Elements of Care. This policy, described in detail in Provision H1, is comprehensive in regard to the requirements of Section H. As noted in the findings of this visit for Section H, Section F,	Noncompliance

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	and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	and others, the policy had not yet been fully operationalized and implemented. That is, the Facility must take action to provide the details needed for implementation, for example, by specifying the clinical indicators to be used by various disciplines in assessing and documenting status of individuals with common and/or serious conditions (including who is responsible for such documentation, where it is placed in the record, and how often it is monitored). The Facility must work to ensure the policy requirements are implemented. Nonetheless, the Monitoring Team compliments the Facility on moving forward with developing this policy. A draft DADS state policy addressed Provisions G and H together. Although this policy had been initiated in November 2010, it had not yet been completed and implemented.	

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. RGSC Section I Self-assessment 5/7/14 2. RGSC Section I Action Plan 5/7/14 3. RGSC Section I Presentation Book 4. DADS At-Risk Policy 006.1 (12/7/12) 5. RGSC Policy 400-02 At-Risk Individuals 3/14 6. RGSC Policy 500-02 Physical and Nutritional Management 3/14 7. Physical and Nutrition Management Team (PNMT) Monitoring Process 12/13 8. Sample O.1: Individuals #5, #19, #33, #46, #60, #77, #103, and #145, 9. Sample O.2: Individuals #79 and #126 10. Sample O.3: Individuals #19, #79, and #126 11. Sample O.4: Individuals #2, #19, and #115 12. Nursing review for Individuals #62, #38, #75, #103, #115, #29, #19, #108, and #126 13. Integrated Risk Rating Form (IRRF), Integrated Health Care Plan (IHCP), and related documents for Individuals #3, #8, #19, #28, #29, #51, #62, #75, #77, #79, #103, #115, #126, #131, #139 and #145 **People Interviewed:** 1. Juan Miguel Gonzalez, Program Improvement Manager (and Section I Lead) 2. Lorraine Hinrichs, ICF-IID Director 3. Jane Augustine PT Director of Habilitation Services 4. Marcy Valdez RN **Meetings Attended/Observations:** 1. ISP Meeting for Individuals #126 and #140 2. Physical Nutritional Management Team (PNMT) meeting 5/20/2014 3. Morning Medical meeting 5/20/14 and 5/21/14 4. Mealtimes and Transitions (La Paloma, El Paisano)
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section I. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section I, in conducting its self-assessment, the Facility: • Did indicate whether or not the self-assessment used monitoring or audit tools. • Reported that it used the Section I monitoring tool for a sample of four Integrated Risk Review Forms (IRRFs) • Reported that it used the Section I monitoring tool for a sample of four Action Plans • Reported that it reviewed policies • Did not report whether it had assessed staff training relevant to the Provisions of Section I related

	policies and procedures. The Self-Assessment did not indicate the methodology for selecting the documents referenced above, the methodology for the review of data, who conducted the review of the documents/data (re: discipline staff, QA staff, or both), whether or not there were written instructions or guidelines associated with the review of data to ensure consistency, or whether there was any inter-rater reliability conducted. The Monitoring Team could not determine whether the scope of the Facility's examination of the sampled data was or was not sufficient to determine compliance with the Settlement Agreement. The Facility Self-Assessment did not address outcomes or clinical indicators related to Section I and did not present data in a meaningful or useful way, reporting primarily only on the presence or absence of data on a particular form. Qualitative self-assessment was not present. The Facility rated itself as being in noncompliance with the three Provisions in Section I. In the last Monitoring Team review the parties agreed to not review Section I of the SA because the Facility reported it had not made progress towards compliance. For this review period the parties agreed the Monitoring Team would conduct reduced monitoring because the Facility reported it had made only limited progress and the noncompliance findings from the last review would stand. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. Actions were reported as complete or in process. The Facility data identified areas of needed improvement but the Action Plan described action steps to address these needed improvements in general and overly broad terms. For example, these included "monitor two medical records per month", or, "provide training for QIDP, therapists, and Nurse Case Managers". The Action Plans did not contain sufficiently targeted steps that would likely lead to compliance with this Section of the SA. For those Provisions determined to be in noncompliance by the Monitoring Team, the Facility will need to examine its Action Plan and make appropriate modifications. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcome and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: The parties agreed the Monitoring Team would conduct reduced monitoring for Section I of the Settlement Agreement (SA), because the Facility reported it had made limited progress; therefore, the noncompliance findings from the last review would stand. In the previous review the parties agreed the Monitoring Team would not monitor this Section, because the Facility reported it had made limited to no progress. This continued lack of progress is troubling to the Monitoring Team. From this review the Monitoring Team determined that the Facility continued to have made limited progress in meeting the requirements of this Section of the SA.

	The Facility prepared a Presentation Book for the Monitoring Team; such a document typically includes substantive documentation that can validate compliance related activities or, at least, areas of progress, for various elements of each Provision of the SA. For Provision I.1 the only documentation presented was a training roster showing that on 2/24/14 fifteen staff were trained on clinical indicators by the PNMT nurse. For Provision I.2 the only documentation presented was a training roster showing that 20 staff were trained on 9/26/13 on PNMP updates and six staff were trained on 3/7/14 on mealtime monitoring, Arjo tub use, gait belt use, lift vest use, and mechanical lift use. For Provision I.3 the documentation provided consisted of a 5/19/14 Section I Quarterly Progress Report submitted to the Facility Settlement Agreement-Program Improvement Council (SA-PIC, the Facility's quality improvement council). The Quarterly Progress Report did not include information that was specific enough to measure progress towards SA compliance. The only other documentation provided were copies of policies the Monitoring Team requested in its pre-visit document request. Training rosters did not specify the job title of those staff who received the training. None of the materials provided in the Presentation Book addressed any of the substantive requirements of this Section of the SA. The Facility's management system to identify individuals whose health or well-being is at risk lacked consistency in implementation and gave the appearance of being disjointed and unorganized. It was not clear that key administrators were sufficiently knowledgeable with regard to the at-risk processes in use at the Facility. ISP meetings did not always adequately address risk related clinical conditions. IHCPs did not always contain necessary information. Implementation was variable.

#	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 conduct reduced monitoring for Section I of the SA, because the Facility reported it had made limited progress. The noncompliance finding from the last review stands. In the previous review the parties agreed the Monitoring Team would not monitor this provision, because the Facility reported it had made limited to no progress. This continued lack of progress is troubling to the Monitoring Team. The Facility prepared a Presentation Book for the Monitoring Team; such a document typically includes substantive documentation that can validate compliance related activities or, at least, areas of progress, for various elements of each Provision of the SA. For Provision I.1 the only documentation presented was a training roster showing that on 2/24/14 fifteen staff were trained on clinical indicators by the PNMT nurse. The training roster did not specify the job title of those staff who received the training. None of the materials provided in the Presentation Book addressed any of the substantive requirements of this Provision.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Facility had made limited progress in meeting the requirements of this Provision. The Monitoring Team completed a comprehensive record review for nine individuals with high/medium risk conditions selected from both units, Individuals #62, #38, #75, #103, #115, #29, #19, #108, and #126. A review of these individuals' records for Assessment and Documentation of Individuals with Acute Changes in Status found no appreciable improvement from the last compliance review in the documentation found in the Integrated Progress Notes. General findings included: • Lack of complete and appropriate nursing assessments of 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 analysis of contributing problematic issues affecting acute changes in status. • Inconsistent initiation of Acute Care Plans and relevant nursing protocols for individuals who experience acute changes in status. • Significant gaps in documentation when the Integrated Progress stated, "will continue to monitor." The nurses consistently failed to state what would be monitored and the frequency of the monitoring. • Lack of follow-up of issues noted in previous nurses' progress notes. • Lack of documentation through to resolution for acute changes in status. • Lack of specific description of physical appearance, size, and location of skin rashes, injuries and/or bruises. • Lack of consistent documentation of the administration and follow-up response to per needed treatments (PRNs). • Lack of mental status assessments documented during status changes and/or specific descriptions when individuals were engaging in maladaptive behaviors. • Lack of documentation that there was communication with other relevant disciplines when there were acute changes in individuals' health or behavior status. In two instances no plan was developed by the IDT to address risks identified through assessments. This was the case for Individuals #103 (high risk related to osteoporosis) and #29 (high risk related to infections). Additionally where plans were developed they did not always contain necessary information. For example, the plan for Individual #115 did not include an assessment adequate to determine the risk level determination, did not demonstrate adequate integration among all appropriate disciplines, did not incorporate functional and measurable objectives from which the efficacy of the plan could be measured, and did not include clinical indicators to be monitored. Other examples where risk was not accurately identified included: 1. Individual #5 had a history of pharyngeal residue, premature spillage and at times	

#	Provision	Assessment of Status	Compliance
		would steal non-recommended food items but was only listed as being at a medium risk of aspiration. 2. Individual #145 had the second largest number of falls over the past six months and was rated as high risk for falls but was listed as low risk for fractures. 3. Individual #82 was noted to require small bites and cues to slow down but was only listed as a low risk of choking. 4. As reported below, the Monitoring Team review of medical conditions for Individual #126 indicated the individual is at risk for significant pain. There was no evidence to indicate that pain was routinely assessed by an individualized assessment. The Facility reported its primary forum for identifying change of status of Individuals was the daily morning medical meeting. Participants included medical providers, unit nursing staff, and representatives from various departments, including PT/OT, behavioral health, residential services, psychiatry, dietary services, and quality assurance. The purposes of the meetings were to discuss urgent clinical issues to ensure continuity of care, and to enhance clinical management of individuals. Through these daily reviews, emergent issues that could affect an Individual's risk rating (and related risk management plan) would be expected to be identified. In reviewing meeting minutes, and direct observation during the review, found the Facility showed some improvement over time in the integrated participation by representative disciplines. The Monitoring Team did not observe assertive interdisciplinary interaction when discussing clinical cases, and in general, the meeting functioned more like a report of what transpired on the previous day. For example, the Clinic Nurse presenting the reports read the information and rarely paused sufficiently to engage the participants in meaningful interdisciplinary interactions, nor was there sufficient discussion on clinical issues that should require follow-up actions. Neither were there follow-up reports provided on previously discussed issues that included actions for follow-up. Other examples included: 1. It was reported that an Individual had refused medication, and there was no discussion to determine if the medication had eventually been administered, the reason for the medication refusal, and what, if any supports may be needed to assist the Individual in taking medication. For identification of risk, it is important to know the reason for this medication refusal, how often the individual refuses medication, and the areas of risk that may be affected by these refusals. That might lead to changes in risk ratings and to determining whether interventions are needed to improve medication compliance. 2. An Individual, who is known to have significant medical issues, was reported to have fallen on the floor, and there was no discussion to determine if a medical assessment had been completed to help rule out possible injury. Given the complex medical condition of this Individual, a medical examination to assess for possible injury would be appropriate. This could affect rating of risk for fractures, among other	

#	Provision	Assessment of Status	Compliance
		risks. 3. There was no observable evidence that the meeting included identification of when risk levels and related risk management plans should be reviewed, and by whom. ISP meetings did not always adequately address risk related clinical conditions. For example, The Monitoring Team attended the ISP meeting for Individual #126 on Tuesday, 5/20/14, and reviewed the active clinical record, most recent PNMP, and the most recent trigger sheet. Observations by the Monitoring Team and concerns with the Facility's ISP process include: • The Individual's known issue of degenerative spine disease was not addressed at the ISP meeting. Issues such as specific monitoring and reporting parameters for worsening myelopathy and pain should have been addressed at the IDT meeting but was not. Information about this, and any actions to be taken, should have been reflected in prior ISPs, IRRFs, and IHCPs. • This Individual was at risk for significant pain, as evident by underlying medical pathology, including esophagitis, gastritis, possible constipation, and significant degenerative spine disease. The Monitoring Team is concerned that the IDT did not assertively review all potential causes of pain, did not ask to review assessments for of pain, but concluded that the Individual did not experience pain. Furthermore, before discussing risk factors for pain, some members of the IDT did indicate that the Individual manifested maladaptive behaviors prior to bowel movements; however, this issue was not further explored when the IDT was reviewing the risk rating for pain. • On 4/9/14, the BCBA was notified to evaluate the Individual to assess for maladaptive behaviors when transferring. The BCBA reported that the behaviors were most probably associated with an underlying medical condition, and recommended that a medical evaluation be provided. Upon review of the active record, review of medical provider's IPNs, and discussion with the BCBA, the Monitoring Team found no evidence to indicate that a medical assessment was done to evaluate for underlying medical causes resulting in maladaptive behaviors. • Following a colonoscopy, and as reported on the GI consultation report dated 5/21/13, the individual was noted to have had a colon polyp removed, and was at increased risk for colon cancer, and required follow-up colonoscopy in 2018. The issue of increased risk for colon cancer was not addressed at the ISP meeting. Additional information regarding this ISP meeting can be found in Provision L.1. The Facility's management system to identify individuals whose health or well-being is at	

#	Provision	Assessment of Status	Compliance
		risk lacked consistency in implementation and gave the appearance of being disjointed and unorganized. For Individual #77, data provided to the Monitoring Team for restraint review included a detailed five-page behavioral health review. It appeared that none of these data were used or considered in the development of the IRRF. The IRRF had high risk assigned to cardiac disease, falls, and polypharmacy side effects and medium risk to constipation/bowel obstruction, circulatory disease, weight, diabetes, osteoporosis, fractures, infections, urinary tract infections, skin integrity, seizures, and behavioral health. The IHCP only addressed respiratory compromise (which had a low risk rating) and weight. The Facility's management system for Section I apparently did not include IRRF and IHCP review or these obvious inconsistencies would have been identified and corrected. For Individual #131, the Incident Management Review Team (IMRT), in reviewing a serious injury related to a fall, noted that the IRRF indicated fall risk as medium and the PNMP indicated fall risk as high. It appears management systems at the Facility are not producing consistent and non-contradictory data. Additional examples where risk level assignment and documented clinical conditions were not consistent with one another can be found in Sections L. M, and O. Finally, it was not clear that key administrators were sufficiently knowledgeable with regard to the at-risk processes in use at the Facility. For example, at the review entrance conference it was reported that the Facility used clinical indicators in the IRRF. This was reiterated by the two administrators at the Section Lead interview. In its review of IRRFs the Monitoring Team did not find consistent use of clinical indicators. Upon questioning the two administrators reported this was implemented recently and recent IRRFs would have clinical indicators. When the Monitoring Team presented several recent IRRFs to the two administrators for review, no clinical indicators were found. Later that day the administrators acknowledged that the use of clinical indicators in IRRFs had apparently not as yet been implemented and "we'll have to do retraining again." Also at the review entrance conference it was reported the Facility held weekly IRRF review meetings that included the QIDP and Nurse Case Manager. The Monitoring Team was unable to observe this meeting as one was not scheduled during review week. From its self-monitoring the Facility reported an overall 60% compliance score related to this Provision. Based on this review this Provision was not in substantial compliance.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an	The parties agreed the Monitoring Team would conduct reduced monitoring for Section I of the SA, because the Facility reported it had made limited progress. The noncompliance finding from the last review stands. In the previous review the parties agreed the Monitoring Team would not monitor this provision, because the Facility	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	reported it had made limited to no progress. This continued lack of progress is troubling to the Monitoring Team. The information in the Presentation Book provided for Provision I.2 included only a training roster showing that 20 staff were trained on 9/26/13 on PNMP updates and six staff were trained on 3/7/14 on mealtime monitoring, Arjo tub use, gait belt use, lift vest use, and mechanical lift use. The training roster did not specify the job title of those staff who received the training. None of the materials provided in the Presentation Book addressed any of the substantive requirements of this Provision. From its self-monitoring the Facility reported a 60% compliance score related to this Provision. Please refer to the discussion presented in Provision I.2 for examples related to noncompliance with this Provision. Based on this review this Provision was not in substantial compliance.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	The parties agreed the Monitoring Team would conduct reduced monitoring for Section I of the SA, because the Facility reported it had made limited progress. The noncompliance finding from the last review stands. In the previous review the parties agreed the Monitoring Team would not monitor this provision, because the Facility reported it had made limited to no progress. This continued lack of progress is troubling to the Monitoring Team. The information in the Presentation Book provided for Provision I.3 consisted of a 5/19/14 Section I Quarterly Progress Report submitted to the Facility SA-PIC and copies of policies the Monitoring Team requested in its pre-visit document request. None of the materials provided in the Presentation Book addressed any of the substantive requirements of this Provision. The progress report did not include information which was specific enough to measure progress towards SA compliance. For example, the report noted that monitoring tool results yielded an overall compliance score of 22% and no inter-rater reliability had occurred. A progress report to the SA-PIC should not just reiterate summary facts but also highlight areas of compliance that are doing reasonably well and others that are not doing well at all. The progress report should also include detailed actions that are planned to move the Facility towards compliance. In observing the SA-PIC during review week where this report was presented, the Monitoring Team noted that discussion in this regard did not occur. From its self-monitoring the Facility reported a 53% compliance score related to this	Noncompliance

#	Provision	Assessment of Status	Compliance
		Provision. Please refer to the discussion presented in Provision I.1 for examples related to noncompliance with this Provision. Based on this review this Provision was not in substantial compliance.	

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, May 2014 2. RGSC Self-Assessment, 5/7/2014 3. RGSC Action Plan, 5/7/2014 4. DADS Policy 008.3 Behavioral Health Services Department Policy, dated 11/5/2013 5. Annual and quarterly psychiatric assessments for Individuals #103, #65, #140, #6, #36, #139, #33, #48, #51, and #55 6. List of all individuals referred to psychiatrist for evaluation of a new behavioral or psychiatric issue during the reporting period 7. List of all individuals admitted to the Facility during the reporting period and date admitted 8. Copy of Reiss screen report for all Reiss Screens completed during the reporting period (Individuals #7, #103, #62, and #38) 9. Schedule documenting meetings among the psychologist and psychiatrist 10. Behavioral data for Individuals #103, #65, #140, #6, #36, #139, #33, #48, #51, and #55 11. Most recent annual psychology assessments for Individuals #103, #65, #140, #6, #36, #139, #33, #48, #51, and #55 12. Most recent structural and functional behavior assessment for Individuals #103, #65, #140, #6, #36, #139, #33, #48, #51, and #55 13. Positive behavioral support plan for Individuals #103, #65, #140, #6, #36, #139, #33, #48, #51, and #55 14. List of all Individuals who were prescribed a new psychotropic medication, for non-emergency use, during the reporting period 15. Most recent quarterly psychiatric assessment for Individuals #22, #63, #139, #46, #150, #44, #15, and #28 16. Psychotropic polypharmacy meeting minutes for 12/17/2013, 1/14/2014, 3/14/2014, 4/23/2014, and 5/19/2014 17. List of individuals prescribed intra-class polypharmacy 18. All MOSES and DISCUS reports that were assessed during the reporting period for Individuals #7, #5, #133, #27, #28, and #131 19. Copy of new consent form 20. Document titled "List of RGSC Patients" 21. Form documenting collaborative effort among psychiatrist and neurologist for Individuals #31, #55, #45, #33, #6, #140, #145, #133, #131, and #27 **People Interviewed:** 1. David Moron, MD (Clinical Director) 2. Ramona Rogers, MD (Chair, Polypharmacy Committee) **Meeting Attended/Observations:**

	1. Psychotropic Polypharmacy workgroup meeting, 5/19/14
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section J. 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 J in conducting its self-assessment: • The Facility did not use monitoring/audit tools that relied on sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement. • The monitoring tools did not note sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes. • The Self-Assessment did identify the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall. The sample sizes were adequate to consider them representative samples. The number or percent of sample size of individuals/records as compared to the overall population was not consistently included in the Self-Assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was not provided by months, quarters, but only provided overall percentage of compliance. • The Monitoring Team determined that the Facility's monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results through inter-rater reliability process completed by the QA department. This was evident by the lack of consistency among the various sections reviewed for this Provision. • It was unknown to the Monitoring Team if sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools; however, based on self-assessments for the past three compliance reports, the outcome of the self-assessment appeared consistent. The Monitoring Team concurs with the Facility's self-assessment of substantial compliance for Sections J.1 through J.3, J.5 through J.9, and J.11. The Monitoring Team disagrees with the Facility's self-assessment of substantial compliance for Sections J.10 and J.12 and determined noncompliance. The Monitoring Team agrees with the Facility's self-assessment of noncompliance with Sections J.14 and J.15. The Facility determined noncompliance for Section J.13, but the Monitoring Team determined substantial compliance. Per review of the self-assessment for J.13, the Facility determined noncompliance because the psychiatrist did not consistently sign the attendance record for the IDT meetings that were held for the annual and quarterly psychiatric assessments; however, the psychiatrist did sign the actual assessment, indicating the psychiatrist's participation at the IDT. This issue was also discussed with the clinical director, who informed the Monitoring Team that psychiatric assessments would not take place if the psychiatrist was not present. For these reasons, the Monitoring Team determined substantial compliance for Section J.13. For Section J.10 the self-assessment indicated that the Facility "continues to be in compliance"; however,

	per review of the last compliance report, the Facility was not in substantial compliance. Furthermore, the self-assessment determined compliance based on review of 12 quarterly psychotropic medication reviews; however, Section J.10 requires an IDT review whenever a new psychotropic medication is prescribed, and per the documents provided, the Facility did not ensure an IDT review to assess risks and benefits before starting a new psychotropic medication. The self-assessment for Provision J.12 determined substantial compliance based on its findings of MOSES and DISCUS assessments being completed as necessary; however, the Monitoring Team determined noncompliance because all of the MOSES and DISCUSS assessments provided for review did not include the prescriber's component of the assessment tool. The assessment component is required by the MOSES and DISCUS assessment tools, and is essential when diagnosing side effects, including dyskinesia. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. • The Facility data did not identify areas of need or improvement • The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section but merely stated what the QA department would assess.
	Summary of Monitor's Assessment: The Facility made some improvements in the area of psychiatric services, including the development of a new consent form and process for psychotropic medications, and a new process that ensures collaboration between the psychiatrist and neurologist when prescribing psychotropic medications to individuals with comorbid psychiatric and seizure disorders. No new substantial compliances were identified during this compliance review. The Monitoring Team strongly encourages the Facility to continue developing systems to address the remaining five noncompliant sections. The following are specific comments, and concerns specific to Sections J.1 through J.15. **Section J.1**: 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. **Section J.2:** 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. **Section J.3:** The Facility continued a process that ensured psychotropic medications were not used as a substitute for a treatment program, or for staff convenience, and for the documents reviewed, continued to incorporate appropriate DSM diagnosis for conditions that were treated by psychopharmacology. **Section J.4:** Because the Facility had not yet fully developed a process to ensure appropriate usage of pre-treatment sedation, the Facility remains not in compliance with Section J.4.

	Section J.5: 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. **Section J.6:** 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. **Section J.7:** The Facility demonstrated its ability to ensure that Reiss screening is completed as clinically necessary, and substantial compliance for Section J.7 will continue. **Section J.8:** Because the psychiatric assessments used to assess Section J.8 were comprehensive, and included data and data analysis for targeted behaviors, the Monitoring Team will continue substantial compliance for Section J.8; however, the Monitoring Team strongly recommends that the Facility ensure it provides more recent psychology assessments, and relies on more current behavioral data, in order to ensure accurate assessment that can lead to appropriate decisions on treatment. **Section J.9:** The comprehensive structural and functional behavior assessment and positive behavior support plans reviewed were incorporated into the psychiatric assessment; and 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. **Section J10:** Because the IDT did not review the risks and benefits associated with prescribing new psychotropic medications, the Facility is not in compliance with Section J.10. **Section J11:** The Facility continued to provide clinically appropriate reviews of psychotropic polypharmacy by the polypharmacy workgroup meeting; however, the pharmacist did not actively participate at most meetings, and should be an active participant of this meeting. The polypharmacy workgroup committee reviewed all Individuals on the list of individuals who were prescribed psychotropic polypharmacy, at least quarterly; however, because the list included only individuals on inter-class polypharmacy, the Monitoring Team is concerned that not all individuals who are prescribed psychiatric polypharmacy, as defined by the Settlement Agreement (SA), are being assessed through the polypharmacy workgroup committee. The Facility continues substantial compliance for this review; however, continued compliance in the future will require that the Facility provides documentation, including an alpha list of all individuals prescribed psychotropic polypharmacy, as defined by the SA. **Section J.12:** The Facility's process to ensure clinically appropriate monitoring for dyskinesia was found to be ineffective. The Facility only recently had begun more frequent assessments to monitor for dyskinesia following a change in neuroleptic dosing. The new electronic assessment forms were noted to be disorganized, and not effective for efficacious review of medication side effects. The prescriber did not complete the MOSES and DISCUS assessments, as required for each assessment tool. For these reasons, the

	Facility is not in substantial compliance with Section J.12. **Section J.13**: As per the last compliance review report, the Facility continued to ensure 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 parameters would be used to assess efficacy. For these reasons, the Monitoring Team determined substantial compliance for Section J.13. **Section J.14:** The Facility had developed a new consent process, which is currently being implemented at the Facility and will be reviewed at future compliance reviews. Because the Facility had not yet substantially implemented the new consent process for psychotropic medications, the Facility is not in substantial compliance with Section J.14. **Section J.15:** The Facility had developed and implemented a clinically appropriate collaborative effort between the treating neurologist and psychiatrist; however, there was no evidence documenting that recommendations and follow-up plans were incorporating into the individual's psychiatric treatment plan, and no evidence that the information was reviewed by the IDT. The Monitoring Team compliments the Facility for developing this collaborative process. Compliance will require evidence that the recommendations and follow-up plans derived by the collaborative effort between the psychiatrist and neurologist are well documented in the form of a psychiatric treatment assessment, such as the quarterly or annual psychiatric assessment, and are reviewed through the IDT process.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	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.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	The 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.	Substantial Compliance
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications	To assess if individuals prescribed psychotropic medication had a non-pharmacological treatment program, the Monitoring Team relied upon annual and quarterly psychiatric assessments provided for Section J.8 of this report, and determined the following for Individuals #103, #65, #140, #6, #36, #139, #33, #48, #51, and #55 :	Substantial Compliance

	shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	• The annual psychiatric assessment and quarterly psychiatric reviews indicated an integration of behavioral data into the psychiatric assessment by the psychiatrist in eight out of ten examples (80%). • Ten out of ten psychiatric assessments or quarterly psychotropic medication review (100%) utilized DSM-IVR criteria when developing a psychiatric diagnosis. • In ten out of ten examples (100%) there was evidence to indicate that a bio-psycho-social hypothesis was developed and assessed by the psychiatrist. • For each example reviewed, the psychiatric assessment documented a review of non-pharmacological interventions in ten out of ten examples (100%) <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. As reported in Section C and Section N, state psychotropic medications were used as restraint without consultation with the behavioral health specialist. These situations did not appear to constitute use of psychotropic medication as punishment. The Facility must take care to follow its policies in regard to use of state psychotropic medications in order to ensure they are not used as punishment but are only used when less restrictive measures have been attempted or considered, and there is imminent risk of harm to the individual or others. <u>Conclusion:</u> The Facility continued a process that ensured psychotropic medications were not used as a substitute for a treatment program, or for staff convenience, and for the documents reviewed, continued to incorporate appropriate DSM diagnosis for conditions that were treated by psychopharmacology.	
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	During the on-site interview with the Facility's clinical director, the Monitoring Team was informed that the Facility was currently developing processes to reduce or eliminate the need for pre-treatment sedation, but has not implemented a process to ensure that the individual support plan (ISP) for individuals requiring pre-treatment sedation, includes such treatment strategies, and that the use of pre-treatment sedation will be coordinated with other medications, supports, and services, including psychiatry, pharmacy, and medical services. At the time of this compliance review, the Facility had developed a new ISP format to address requirements for Section J.4. Conclusion: Because the Facility had not yet fully developed a process to ensure appropriate usage of pre-treatment sedation, the Facility remains not in compliance with Section J.4.	Noncompliance

	medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.		
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.	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.	Substantial Compliance
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	The 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.	Substantial Compliance
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals	To assess if Reiss Screens were completed for all new admissions to the Facility, and when an individual is referred to psychiatric assessment, the Monitoring Team requested: • List of all individuals referred to psychiatrist for evaluation of a new behavioral or psychiatric issues, during the reporting period • List of all individuals admitted to the Facility during the reporting period and date admitted • Copy of Reiss Screen reports for Reiss Screens completed during the reporting period The Facility provided documentation indicating that no individuals were newly referred to the psychiatrist for either a behavioral or psychiatric issue. The Facility provided a list that included the names of all new admissions to the Facility occurring during the reporting period. The Facility provided copies of completed Reiss screen reports for Individuals #7, #103,	Substantial Compliance

	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.	#62, #38. Conclusion: The Facility demonstrated its ability to ensure that Reiss screening is completed as clinically necessary, and substantial compliance for Section J.7 will continue.	
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 data, and psychiatric assessments for the first ten individuals on a list of all individuals who were prescribed a psychotropic medication (Individuals #103, #65, #140, #6, #36, #139, #33, #48, #51, and #55). By review of the most recent psychiatric, and psychology assessments, for Individuals #103, #65, #140, #6, #36, #139, #33, #48, #51, and #55, the Monitoring Team noted review and incorporation of behavioral data into the psychiatric assessments in eight out of ten examples (80%); however, the Monitoring Team noted that for many examples, as described below, data used for the most recent psychiatric assessment was from date ranges well before the psychiatric assessment, and therefore did not represent the current status of the individuals. The following is a summary of the Monitoring Team's review of the documents: • 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 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 eight out of ten examples (80%), 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%), quarterly psychiatric medication reviews and annual psychiatric assessments were completed as a part of the IDT; the psychiatrist, nurse, psychologist, the direct care support staff, and the QIDP were documented to have attended the IDT. The clinical director informed the Monitoring Team that	Substantial Compliance

		when necessary, the psychiatrist could have the medical provider join the quarterly psychiatric medication review by phone. The Monitoring Team is concerned that the Facility relied upon behavioral data that was derived considerably prior to the psychiatric assessment, or in two cases, no data was provided at all. For example: • Seven out of ten examples (70%), did not provide graphic representation, or current data analysis regarding target behaviors, within the context of the quarterly psychiatric assessment. o Individual #65: The most recent annual psychiatric assessment was dated 10/20/13, and the most recent quarterly psychiatric assessment was dated 7/23/2013; therefore, a current psychiatric quarterly or annual assessment was not dated within this compliance review period. o Individual #6: The most recent quarterly psychiatric assessment was dated 3/13/2014, and neither graphic representation nor data analysis of behavioral data was documented within the context of the 3/13/2014 quarterly psychiatric assessment. Furthermore, the most recent psychology assessment provided for review was dated 5/17/2012. o Individual #36: The most recent annual psychiatric assessment provided for review was dated 8/6/2012; and is 9 months overdue. The most recent quarterly psychiatric assessment was dated 1/23/2014; however, the data graph documented within the context of this assessment was dated 3/2014, which was after the date indicated on the assessment. It appeared, therefore, that the data were added after the quarterly psychiatric assessment and could not have been considered in making decisions at that assessment. o Individual #33: Data used for the 2/10/2014 quarterly psychiatric assessment was dated 12/2013; thus, the Facility relied upon data that was from two months prior to the assessment. o Individual #48: Data used for the 2/23/2014 quarterly psychiatric assessment was dated 12/2013; the Facility relied upon data that was from two months prior to the assessment. o Individual #51: Data used for the 2/13/2014 quarterly psychiatric assessment was dated 12/2013; the Facility relied upon data that was from two months prior to the assessment. o Individual #55: Data used for the 12/3/2013 quarterly psychiatric assessment was dated 9/2013; the Facility relied upon data that was from three months prior to the assessment. No more recent quarterly psychiatric assessment was provided. Also of concern was that annual psychology assessments that were provided for review	

		were dated more than one year prior to the quarterly psychiatric assessment, in many cases; the most recent psychological assessments for five out of ten examples (50%) were dated greater then one year prior. The quarterly psychiatric assessments for those five examples did not document review of current behavioral data. • Individual #36: 5/17/2012 • Individual #139: 10/3/2012 • Individual #33: 11/12/2012 • Individual #48: 8/17/2012 • Individual #55: 2/28/2012 Conclusion: Because the psychiatric assessments used to assess Section J.8 were comprehensive, and included data and data analysis for targeted behaviors, the Monitoring Team will continue substantial compliance for Section J.8. At this visit, the Monitoring Team reviewed the behavioral data provided and considered in developing the psychiatric assessment and found it not consistently current. To ensure accurate assessment that can lead to appropriate decisions on treatment, and for compliance to be found at the next visit, the Facility must ensure assessments rely on more current behavioral data.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for	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 per the document request for Section J.8 (Individuals #103, #65, #140, #6, #36, #139, #33, #48, #51, and #55), copies of the most recent psychiatric assessment, structural and functional behavior assessment and positive behavior support plan, annual psychology assessment. • 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 K5): o Ten out of ten examples (100%) indicated a comprehensive and clinically appropriate behavioral hypothesis. o Ten out of ten examples (100%) documented clinically appropriate rationale for the current behavior and pharmacological treatment.	Substantial Compliance

	psychotropic medication to the degree possible.	○ In ten out of ten examples (100%) the PBSP documented clinically appropriate observable behavioral indices that were consistent with targeted behaviors delineated on the psychiatric assessment. Although there was improvement regarding integration of assessments targeting behavior and mental illness, there were examples in which there was no discussion of the relationship between behavioral indices and either the diagnosed mental illness or behavioral targets. It should be noted that the SFA itself, as reported in Provision K5, did not specify behavioral indices of psychopathology. ○ Ten out of ten (100%) examples indicated specific behavioral outcome data and objectives. ○ Ten out of ten (100%) examples documented behavioral intervention strategies for staff to address behavioral exacerbations. ○ The SFA reports did not consistently describe differentiation between learned and biologically based behaviors. ○ 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. Conclusion: The Monitoring Team continues to be extremely impressed by the clinically appropriate and comprehensive structural and functional behavior assessment and positive behavior support plans, which were incorporated into the psychiatric assessment; and that these plans are integrated in the IDT and ISP process. 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	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: • List of all individuals who were prescribed a new psychotropic medication, for non-emergency use, during the reporting period • Copy of IDT minutes or other documents delineating the IDT's review of psychiatric treatment The Facility provided a list of 14 individuals who had a new psychotropic medication started, along with the name of the medication/s, and date the medication was prescribed. In addition, the Facility provided eight quarterly medication assessments, which were derived from the list of individuals having a new psychotropic medication initiated during the review period. The Monitoring Team requested examples from the first ten individuals on the list; however, no documents were provided for Individual	Noncompliance

	likely to be less effective or potentially more dangerous than the medications.	#65, and documents were provided for Individual #103, who was not on the list, but included did not include documents for Individual #145, who had a similar name as Individual #103. For the eight examples reviewed (Individuals #22, #63, #139, #46, #150, #44, #15, and #28), zero out of eight (0%) indicated a review of the newly prescribed medication by the IDT. It should be noted that there was no discussion or other form of documentation by the IDT documenting a review for the drug listed on the list of Individuals who were prescribed a new psychotropic medications. Conclusion: Because the IDT did not review the risks and benefits associated with prescribing new psychotropic medications, the Facility is not in compliance with Section J.10.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	To review the Facility's management of psychotropic polypharmacy the Monitoring Team reviewed the documents provided for Section N.3 of this report, and refers the reader to Section N.3 of this report for additional information: • Psychotropic polypharmacy meeting minutes for 12/17/2013, 1/14/2014, 3/14/2014, 4/23/2014, and 5/19/2014 • List of all individuals on psychotropic polypharmacy The Facility provided a list of inter-class polypharmacy; however, the Facility did not provide a list of individuals on polypharmacy as defined by the Settlement Agreement. For example, the Facility is to maintain data on individuals who are prescribed two or more psychotropic medications, regardless of class. As per the last compliance report, the Monitoring Team noted that the Facility's systems review of psychotropic polypharmacy, and the psychotropic polypharmacy workgroup meetings that review psychotropic polypharmacy at the level of the individual, demonstrated a clinically meaningful mechanism to assess polypharmacy; however, the five psychotropic polypharmacy meeting minutes provided for review (2/12/2014, 3/4/2014, 3/26/2014, 4/23/2014, and 5/19/2014) reported a pharmacist was only present for one out of the five meetings (20%), the 3/26/2014 meeting. A pharmacist should be a regular and active participant at the psychotropic polypharmacy workgroup meeting. The psychiatrist, chief executive nurse, and BCBA did participate regularly. Psychotropic polypharmacy data, and summary of the data that was provided for review was documented on six occasions (12/17/2013, 1/14/2014, 3/14/2014, 4/23/2014, and 5/19/2014) clearly documented polypharmacy usage at the Facility, and categorized the data by the numbers of drugs, specific class of drugs, and specific individual drugs that resulted in polypharmacy. The Monitoring Team could not determine the total rate or percentage of individuals prescribed psychotropic medications who had	Substantial Compliance

		polypharmacy, as this data was not apparent upon review of the documents. During the reporting period, the Facility indicated that the incidence of polypharmacy increased from 20 individuals being prescribed psychotropic polypharmacy on 12/17/2013 to 26 individuals being prescribed psychotropic polypharmacy on 5/19/2014-- a total of six additional individuals being prescribed psychotropic polypharmacy. The summary of the data stated that the increased number of individuals being prescribed psychotropic polypharmacy was secondary to the new admissions to the Facility, but data were not provided to support this statement. The psychotropic polypharmacy work group conducted specific reviews on a total of 43 individuals during this reporting period. The Monitoring Team observed a polypharmacy workgroup meeting on May 19, 2014, and during that meeting the workgroup reviewed current clinical records, including psychiatric assessments, and documented specific comments and recommendations, which were communicated to the treating psychiatrist for nine Individuals; the Monitoring Team can not comment on the specific examples because the name key used by the polypharmacy workgroup is different from the name key used for this report. Summary: The Facility continues to provide clinically appropriate reviews of psychotropic polypharmacy by the polypharmacy workgroup meeting; however, the pharmacist did not actively participate at most meetings, and should be an active participant of this meeting. The polypharmacy workgroup committee reviewed all Individuals on the list of individuals who were prescribed psychotropic polypharmacy, at least quarterly; however, because the list included only individuals on inter-class polypharmacy, the Monitoring Team is concerned that not all individuals who are prescribed psychiatric polypharmacy, as defined by the SA, are being assessed through the polypharmacy workgroup committee. The Facility continues substantial compliance, however, continued compliance in the future will require that the Facility provides documentation, including an alpha list of all individuals prescribed psychotropic polypharmacy, as defined by the SA.	
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	Because of significant overlap with Sections N.5 and J.12 of this report, the Monitoring Team refers the reader to Section N.5 for its review of the Facility's utilization of side effects scales to assess side effects secondary to psychotropic medications. For Section N.5, the Monitoring Team requested the MOSES and DISCUS assessment that were obtained following a change in dose, or new order for neuroleptic class of drugs. The Facility indicated on the document request form that a total of eight individuals met the criteria; however the Facility only provided six examples (Individuals #7, #5, #133, #27, #28, and #131). The following are the Monitoring Team's concerns and comments for the review of MOSES and DISCUS assessments:	Noncompliance

	quarterly.	• All MOSES and DISCUS assessment provided for review did not include a physician review section. The DISCUS assessment requires that a physician review the form, and indicate if Tardive Dyskinesia is present or absent. • There was no indication of a signature, or an electronic signature, for the medical prescriber's review. • The assessments only listed psychiatric medications, and did not list all of the medication. Because of drug-drug interactions, and clinical effects of other drugs, all drugs must be clearly delineated on the form. • The Facility provided the new electronic versions of the DISCUS and MOSES assessments, and they were all noted to be printed in a way that resulted in challenges for the Monitoring Team assessment of the printed forms. For example, the electronic MOSES assessment report was eight pages long, instead of one page for the original version; assessment categories were abruptly terminated on one page, and continue on the subsequent page, but without a header explaining what was being assessed; and in some occasions, such as for the MOSES dated 4/24/2014 for Individual #7, a scoring scale would be printed between the items assessed for each category. This would make assessment difficult for the Facility as well as for the Monitoring Team. • All examples provided were dated 3/26/2014 through 4/25/2014. There were no other examples provided for medication changes prior to 3/26/2014. During the on-site interview with the clinical director, the Monitoring Team was informed that the Facility had only recently started to ensure that more frequent MOSES and DISCUS assessments were obtained when clinically necessary. In addition to the five examples reviewed, the Monitoring Team reviewed many other MOSES and DISCUS assessments for Sections N.2 and N.3 of this report, and the same concerns as determined for Section N.5 were noted when reviewing those sections. The Facility reported that it had recently implemented the new electronic MOSES and DISCUS reporting system, and during their own internal review had noted that several electronic MOSES and DISCUS reports had not included the physician review section, or included electronic signatures. After the Monitoring Team provided a draft report, the Facility provided copies of handwritten MOSES and DISCUS forms that were completed and signed by the prescriber for Individuals #5, #27, #28, #46, #60, and #139. The Monitoring Team reviewed these and found: • Nine of 15 (60%) DISCUS reports were appropriately completed by the medical provider. • Twelve of twelve (100%) MOSES reports were appropriately completed by the medical provider.	

		Conclusion: The Facility's process to ensure clinically appropriate monitoring for dyskinesia was found to be ineffective. The Facility only recently had begun more frequent assessments to monitor for dyskinesia following a change in neuroleptic dosing; the new electronic assessment forms were noted to be disorganized, and not effective for efficacious review of medication side effects; the MOSES and DISCUS assessments were not completed by the prescriber, as required by for each assessment tool. For these reasons, the Facility is not in substantial compliance with Section J.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 the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	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 #103, #65, #140, #6, #36, #139, #33, #48, #51, and #55): • 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. • Ten out of ten (100%) 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 stated in Section J.6, 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: As per the last compliance review report, the Facility continued to ensure 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,	Substantial Compliance

		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.	The Facility's clinical director informed the Monitoring Team that a new consent process, that will help ensure risks and benefits, expected limitations, alternative treatments, and expected time frames for treatment effects to occur has been developed but not yet substantially implemented at the Facility, but will be substantially implemented by in the near future. The Monitoring Team was provided a copy of the new consent form, and following review, the consent form appears to cover the requirements of the SA. Conclusion: The Facility had developed a new consent process, which is currently being implemented at the Facility, and will be reviewed at future compliance reviews. Because the Facility had not yet substantially implemented the new consent process for psychotropic medications, the Facility is not in substantial compliance with Section J.14.	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.	To assess the collaborative efforts between psychiatry and neurology, that ensures the coordination of medications when they are prescribed to treat both seizures and mental health disorders, the following documents were requested:
		• List of all individuals who are prescribed an anticonvulsant for both behavioral and neurologic indications
		  ○ Include name and dose of medication
		  ○ List specific psychiatric and neurologic diagnosis
		• For the first ten individuals on the list above, provide specific IDT meeting minutes that document the neurologist's and psychiatrist's collaboration when prescribing, discontinuing and assessing medications used for both psychiatric and neurologic indication
		• Provide all relevant documented evidence describing the Facility process to ensure regular collaboration between psychiatrist and neurologist.
		
		The Facility's clinical director informed the Monitoring Team that the Facility had contracted with the prescribing neurologist to collaborate with the psychiatrist on all individuals who have both a psychiatric and seizure disorders.
		
		The Facility provided a list of 15 individuals titled "List of RGSC Patients" and did not indicate if the list was specific for individuals with comorbid psychiatric and neurological conditions.
		
		The Facility provided an untitled form, that appeared to be a form used to document collaborative efforts among the neurologist and psychiatrist, along with the most recent
			Noncompliance

		quarterly psychiatric assessment for Individuals #31, #55, #45, #33, #6, #140, #145, #133, #131, and #27. The form was unsigned, and did not indicate physician names; however, the form was accompanied by a cover sheet that stated "Documentation from Dr. (psychiatrist) telephone meeting with neurologist". Examples of communication between the psychiatrist and neurologist was provided for the first ten individuals on the list provided (Individuals #31, #55, #45, #33, #6, #140, #145, #133, #131, and #27). • In ten out of ten examples (100%), the completed form documented the diagnosis, current medications, potential contraindications, specific pharmacologic recommendations, and follow-up plan. • In zero out of ten examples (0%), there was documented evidence indicating that the collaborative recommendations had been integrated into the psychiatric treatment plan, or other documentation indicating review by the IDT. All ten quarterly psychiatric assessments provided for review were completed prior to the form documenting the neurologists and psychiatrist's recommendations. Conclusion: The Facility had developed and implemented a clinically appropriate collaborative effort between the treating neurologist and psychiatrist; however, there was no evidence documenting that recommendations and follow-up plans were incorporated into the individual's psychiatric treatment plan, and no evidence that the information was reviewed by the IDT. The Monitoring Team compliments the Facility for developing this collaborative process. Compliance will require evidence that the recommendations and follow-up plans derived by the collaborative effort between the psychiatrist and neurologist are well documented in the form of a psychiatric treatment assessment, such as the quarterly or annual psychiatric assessment, and are reviewed through the IDT process.	

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 – 5/7/2014 2. RGSC Action Plan – 5/7/2014 3. RGSC Presentation Book for Section K 4. Documents that were frequently reviewed included the facility tracking data from spreadsheets and databases, 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. • The review of data monitoring practices in K.4 included Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. • The review of Psychological Assessment reports in K.5 included Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. • The review of SFAs concerning assessment of behavior in K.5 included Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. • The review of SFAs in the context of the integration of mental illness and behavior assessment in K.5 included Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. • The review of psychological testing, including adaptive skills and intelligence, in K.6 included Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. • 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 #7, #38, #62, and #103. • The review of PBSPs in K.9 included Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. • The review of data graphs in K.10 included Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. **People Interviewed:** 1. Ruben Nieto, BCBA – Behavior Services Director 2. Bernice Martinez, BCBA – Facility behavior analyst 3. Megan Gianotti, BCBA – Contract behavior analyst 4. Samantha Salinas, BCBA – Contract behavior analyst 5. Michelle Melchor – Psychology Assistant 6. Aurora Reyna – Psychology Assistant 7. Vanessa Alvarez - Human Rights Officer 8. Approximately 15 direct care staff in both Facility residences as well as vocational and day treatment

areas.

Meetings Attended/Observations:

1. Peer review meeting
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.

Based upon the problems encountered in obtaining the documents requested as part of the site visit, the validity and accuracy of the Facility's Self-Assessment was brought into question. Developing a comprehensive and accurate self-assessment requires that all relevant documents and data be current, well organized, and accessible. A request for documentation relevant to Section K was submitted on-site during the site visit. Due to missing documents, two more requests were submitted to the Facility in the two and one half weeks following the site visit. Despite these multiple requests, many requested documents were not made available. No specific reason was provided for the missing documents.

The documents that were not submitted included documents essential to the Self-Assessment process, including Structural/Functional Assessments (SFAs), Positive Behavior Support Plans (PBSPs), psychological assessment reports, and progress notes. If these documents were not available for submission to the Monitoring Team, it was unlikely that they would have been available for the development of the Self-Assessment. It is recommended that the Facility take all necessary action to ensure that records are current, organized, and accessible.

The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. This Action Plan was incomplete, including plans only for the first six provisions of Section K. Based upon this partial Action Plan, the following conditions were evident.

- 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 5/19/2014 through 5/23/2014. Record reviews continued off-site following the site visit.

The process of completing the assessment of Section K was complicated substantially by the difficulty in obtaining the documents essential to the review process. As noted elsewhere in this report, despite repeated requests not all requested materials were submitted.

	The documents that were submitted to the Monitoring Team suggested that in many cases the Facility had maintained progress toward substantial compliance with the Settlement Agreement. It would have been reasonable to assume that the missing documentation was of comparable quality to the documents that were submitted. There were suggestions, however, that this was not the case. For example, the RGSC spreadsheet used to track PBSPs reflected that at least two of the three PBSPs that were not submitted to the Monitoring Team were over one year old and therefore out of compliance. Due to these issues, for many provisions it was not possible to formulate a comprehensive assessment of Facility performance. Available information did reflect that the Facility employed two BCBAs and that these two BCBAs were solely responsible for conducting behavior assessments and developing behavior interventions. In addition, documentation did indicate that the four people admitted to the Facility since the previous site visit had been provided a psychological assessment report within 30 days of admission.

#	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 and was replaced by another staff who was not a BCBA, and who had since left. 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. Through the May 2013 site visit, Ruben Nieto remained the only full-time, regular employee of RGSC who was a BCBA. At the time of the November 2013, it was revealed that a second BCBA, Bernice Martinez, had been hired. Ms. Gianotti had also become a consultant to the Facility, including participating in the internal peer review of PBSPs. <u>Current Site Visit</u> During the current site visit, Facility records regarding Behavior Services Department staff were reviewed. These records reflected that the Facility continued to employ the two BCBAs noted during the previous site visit, Ruben Nieto and Bernice Martinez. As only two positions in the Behavior Services Department were eligible for board certification, it was determined that 100% of the current Behavior Services Department staff possessed board certification. In addition, the Facility continued to engage Samantha Salinas, MSW, as a consultant; she reported having recently completed	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>requirements for certification as a BCBA.

<table><tr><td></td><td>Baseline</td><td>11/2013</td><td>5/2014</td></tr><tr><td>Percent of staff who were BCBAs</td><td>0%</td><td>100%</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 required that all PBSPs were developed by a BCBA. To assess this practice, a sample of 10 PBSPs (Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139) was requested from the Facility. The Facility failed to provide a current PBSP for three individuals (Individuals #55, #77, and #98). Of the remaining seven PBSPs, all 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</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		review committee, and included Cheryl Fielding, PhD, BCBA, as Chair. Dr. Fielding was a contractual employee at RGSC. In August 2012, the Facility had only recently begun a revised internal and external peer review process. In May 2013, documentation supported a functional internal and external peer review process. The same internal and external peer review procedures were in place during the November 2013 site visit. <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, Dr. Cheryl Fielding, and Megan Gianotti). The process for peer review consisted of the following steps: o The SFA/PBSP was submitted to the internal BCBA reviewer. o The internal reviewer (Megan Gianotti) completed the evaluation tool and met with SFA/PBSP author to review comments and suggestions. o The author revised the SFA/PBSP as needed, with feedback from the internal reviewer, until a rating of 80% was achieved on the evaluation tool. o The internal reviewer forwarded the SFA/PBSP, evaluation tool, and peer review response form to the Peer Review Committee scribe and external BCBA reviewer. o The Peer Review Committee scribe emailed the review materials to the committee members prior to the date of Peer Review Committee meeting. o The external reviewer (Dr. Cheryl Fielding) completed the evaluation tool for 25% of the SFA/PBSPs submitted for internal peer review and forwarded the materials to the Peer Review Committee scribe prior to the committee meeting. o The Peer Review Committee reviewed the SFA/PBSP and evaluation tools, and formulated the committee response. Peer Review Committee minutes reflected that since the previous site visit the full Peer Review Committee did not meet. The Facility reported that Ruben Nieto and Berenice Martinez would frequently meet with the internal peer reviewer, Megan Gianotti, but no minutes or other documentation of meeting occurrences were provided. Completed Peer Review Evaluation Tools were provided, but these documents did not reflect whether a meeting was held. Observations of a Peer Review meeting were conducted on Monday, May 19. Ruben Nieto, Berenice Martinez, and the internal peer reviewer, Megan Gianotti, were present. The discussion involved the SFA and PBSP of Individual #77. All BCBAs present demonstrated considerable expertise and were able to identify weaknesses in the plan, as well as potential revisions.	

#	Provision	Assessment of Status	Compliance
		Based upon observations of the Peer Review meeting, it was indicated that improvements could be made to the peer review process. Although members were knowledgeable of the PBSP and behavior analytic procedures, the review was at times complicated and sidetracked by discussion of the changes that should be made to the PBSP versus the changes that had been mandated by incident management and the IDT. As a result, the peer review meeting did not produce specific and evidence-based conclusions or recommendations. An example observed by the Monitoring Team involved the PBSP for Individual #77. Observations during the peer review discussion regarding Individual #77 indicated the IDT and incident management committee had required changes to intervention targets and strategies even though those changes were not supported by available data. For example, discussion indicated that the BCBAs had been instructed to include medication refusal as the primary target of the PBSP. Data regarding medication refusal presented at peer review, however, revealed that Individual #77 had cooperated with medication requests during 13 out of 14 of recent requests. Discussions also reflected that skin picking had not been approved as a target by the IDT even though observations by the BCBA reflected frequent displays of the behavior. Some of the limitations noted in the internal peer review resulted from these changes required by the IDT and incident management. While the IDT has responsibility to identify issues to be addressed in treatments and interventions, these decisions should be informed by objective information. Documentation provided by the Facility reflected that 10 of 58 individuals with PBSPs (17%) had not had their PBSPs updated in over one year at the time of the site visit. In addition, 18 of 58 individuals with PBSPs (31%) had not had an internal peer review of their PBSPs in over a year. 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. One way to address this would be for the Facility to develop a process whereby the Peer Review Committee reviewed PBSP dates, with follow-up actions to ensure that reviews of intervention plans by the Peer Review Committee lapsed.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures	<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	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>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. In November 2013, some progress was noted but further improvement was needed in ensuring that data were collected and presented correctly, and that decisions concerning behavior interventions were evidence-based.

<u>Current Site Visit</u>
During the current site visit, the Monitoring Team selected a sample of 10 individuals for the review of data collection and treatment monitoring. These individuals included individuals with recent ISPs. The specific individuals included in the sample were Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. Documentation was requested from the Facility for these 10 individuals on three occasions. The Facility failed to provide documentation for three individuals (Individuals #55, #77, and #98).

The table below reflects the results from the current site visit review regarding the collection and presentation of data. Data in the table below are based on review of the seven assessments provided. Because there was no way to review the additional samples requested, which may or may not have included the information below, the Monitoring Team cannot determine whether they would have met the standards in the table. Therefore, the maximum percentage that could meet the standard is 70% (seven received of the 10 requested).
<table>
<tr><th></th><th>3/2010</th><th>11/2013</th><th>5/2014</th></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Data reliability is assessed</td><td>0%</td><td>33%</td><td>0%</td></tr>
<tr><td>Target behaviors analyzed individually</td><td>0%</td><td>100%</td><td>70%</td></tr>
<tr><td>Targeted behaviors graphed sufficient for decision-making</td><td>0%</td><td>83%</td><td>70%</td></tr>
<tr><td>Replacement behaviors graphed sufficient for decision-making</td><td>0%</td><td>83%</td><td>50%</td></tr>
</table>

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.</td><td></td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
It should be noted that the PBSP and structural and functional assessment (SFA) for Individual #77 were available at the peer review meeting observed by the Monitoring Team, although not provided in response to the document request. The internal peer reviewer, however, had identified problems in the selection and definition of targets, the focus of and procedures for the behavior assessment, the intervention strategies, and the data collection procedures. Due to these issues, the SFA and PBSP were rated as not passing peer review and were returned for revision. If these materials had been submitted as part of the document request process, they would not have resulted in an improvement in overall ratings.

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.

<table>
<tr><td></td><td>Baseline</td><td>11/2013</td><td>5/2014</td></tr>
<tr><td>Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level</td><td>0%</td><td>100%</td><td>70%</td></tr>
<tr><td>Review is conducted by a BCBA</td><td>0%</td><td>100%</td><td>70%</td></tr>
<tr><td>Input from direct care staff is solicited and documented</td><td>0%</td><td>100%</td><td>70%</td></tr>
<tr><td>Modifications to the PBSP reflect data-based decisions</td><td>0%</td><td>67%</td><td>50%</td></tr>
<tr><td>Criteria for revision are included in the PBSP</td><td>0%</td><td>100%</td><td>70%</td></tr>
<tr><td>Progress evident, or program modified in timely manner (3 Months)</td><td>0%</td><td>67%</td><td>50%</td></tr>
</table>

The following factors were noted concerning the review of the available 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 question.

Based upon the information obtained during the current site visit, the Facility had not
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<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>made progress in comparison with the previous site visit. If the tables above were based only upon the documentation provided for the seven individuals, the percentages would equivalent to those reported during the previous site visit. As three requests were made of the Facility for the necessary documentation, it can only be presumed that the requested documentation did not exist; for the one individual whose peer review was observed, at least some of the documentation did exist but did not meet standards. As a result, the Monitoring Team cannot conclude that those documents would have indicated increased compliance with the standards.</td><td></td></tr>
<tr><td>K5</td><td>Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.</td><td><u>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 evaluations 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. Some improvement was noted during the November 2013 site visit, although several areas of weakness remained.

<u>Current Site Visit</u>
During the current site visit, the Monitoring Team selected a sample of 10 individuals for the review of psychological assessment. This sample included individuals with recent ISPs. The specific individuals included in the sample were Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. Current psychological assessment reports were requested from the Facility for these 10 individuals. The Facility failed to provide a psychological assessment report for two individuals (Individuals #77and #98). For six additional individuals (Individuals #27, #55, #59, #63, #84, and #139), the Facility provided a psychological assessment report that was in excess of a year old. Only the reports for Individuals #6 and #28 were current.

<table>
<tr><th></th><th>Baseline</th><th>11/2013</th><th>5/2014</th></tr>
<tr><td>A Psychological Assessment had been completed.</td><td>0%</td><td>100%</td><td>80%</td></tr>
<tr><td>The Psychological Assessment was less than one year old</td><td>0%</td><td>100%</td><td>20%</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>80%</td></tr>
<tr><td>The Psychological Assessments contained</td><td>0%</td><td>50%</td><td>20%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status				Compliance
		findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.				

Information obtained from the sample records, as well as interviews with staff, indicated that assessments of intelligence and adaptive skills were no longer routinely 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 66 individuals (97%).
- Testing of adaptive skills had been completed in under one year for 10 of 66 individuals (15%).
- Psychological evaluation reports had been completed in under one year for 45 of 66 individuals (68%).

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 sample used for the table above was also used for this review.

	Baseline	11/2013	5/2014
Psychological Assessments included a narrative summary of how the results from intellectual assessments would facilitate the understanding of the individual's strengths and needs.	0%	0%	0%
Psychological Assessments included a narrative summary of how the results from adaptive assessments current or otherwise would facilitate the understanding of the individual's strengths and needs.	0%	0%	0%

Based upon information obtained from the Facility, it appeared that several limitations remained concerning Psychological Evaluation reports and the testing of individual abilities.

<u>Behavior Assessment</u>
The assessment of behavioral function is an essential component of effective behavior change and requires more than the completion of a screening tool, interview or series of observations. Determining the function of a behavior is an empirical process that begins

#	Provision	Assessment of Status	Compliance
		with general observation and progresses with increasing control and focus through screenings, interviews and formal observations until a specific hypothesis regarding the function or purpose of the undesired behavior is developed. An acceptable functional assessment or functional analysis does not produce a series of ambiguous statements regarding the function of the undesired behavior. Rather, the product of the assessment process is a specific statement regarding the most likely function of the behavior or an indication of how ambiguous findings will be resolved. Without additional investigation, ambiguous statements are indicative of an assessment process that has not been completed. <u>Historical Perspective</u> 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. The November 2013 site visit 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. <u>Current Site Visit</u> During the current site visit, the Monitoring Team selected a sample of 10 individuals for the review of behavior/functional assessments. These individuals included individuals with recent ISPs. The specific individuals included in the sample were Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. Documentation was requested from the Facility for these 10 individuals on three occasions. The Facility failed to provide documentation for three individuals (Individuals #55, #77, and #98). Review of the tracking spreadsheet for these individuals revealed: • For Individual #55, the PBSP was last implemented 2/9/13. A new PBSP was being developed but had not been implemented. • A PBSP for Individual #77 was going through peer review during the compliance visit. Multiple dates were given for the last implementation. • For Individual #98, the date provided for implementation was 4/26/13. Data in the table below are based on review of the seven assessments provided. Because there was no way to review the additional samples requested, which may or may not have included the information below, the Monitoring Team cannot determine whether they would have met the standards in the table.	

#	Provision	Assessment of Status	Compliance

	Baseline	11/2013	5/2014
Assessment or review of biological, physical, and medical status	0%	100%	70%
Review of personal history	0%	100%	70%
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	0%	100%	70%
The process or tool utilizes both direct and indirect measures	0%	100%	70%
Identification of setting events and motivating operations relevant to the undesired behavior	0%	100%	70%
Identification of antecedents relevant to the undesired behavior	0%	86%	70%
Identification of consequences relevant to the undesired behavior	0%	100%	70%
Identification of functions relevant to the undesired behavior	0%	100%	70%
Summary statement identifying the variable or variables maintaining the target behavior	0%	100%	70%
Identification of functionally equivalent replacement behaviors relevant to the undesired behavior	0%	100%	70%
Identification of preferences and reinforcers	0%	100%	70%

There were also indications that SFAs were not completed as often as necessary, and at least once per year. The Facility tracking spreadsheet revealed that at the time of the current site visit 15 of 58 individuals provided a PBSP (26%) had not had their SFA reviewed or revised within the past year.

If the table above were based only upon the documentation provided for the seven individuals, the percentages would be the same as those reported during the previous site visit. As three requests were made of the Facility for the necessary documentation, it can only be presumed that the requested documentation did not exist. Therefore, in light of the lack of consistent timeliness of completing SFAs as well as the inability to assess all requested documents, the Monitoring Team cannot conclude that the standards found at 70% were met consistently across the requested sample.

The SFA for Individual #77 was available at the peer review meeting, although not provided in response to the document request. The internal peer reviewer, however, had

#	Provision	Assessment of Status	Compliance
		identified problems in focus of and procedures for the behavior assessment. If the SFA had been submitted as part of the document request process, it would not have resulted in an improvement in overall ratings. During the current site visit, the same sample reported immediately above revealed the following about the integration of mental illness and behavior assessment.	

	Baseline	11/2013	5/2014
The assessment process included screening for psychopathology, emotional, and behavioral issues.	0%	50%	0%
The assessment process included differentiation between learned and biologically based behaviors.	0%	0%	0%
Identification of behavioral indices of psychopathology	0%	67%	0%
Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities	0%	50%	0%

The SFAs that were available for review reflected considerable shortcomings in comparison with the previous site visit. All SFAs included some presentation of mental illness diagnoses and potential relationships between environmentally based behavior and symptoms of mental illness. In none of the SFAs, however, was there reflected an attempt to explore through functional assessment or other behavior analytic procedures the specific relationships between behavior and mental illness. As a result, based upon the information in the SFA, it was not possible to determine the circumstances when either behavior analytic strategies or psychotropic medication, or a coordinated use of both, would provide the most appropriate intervention.

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.

- *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.*

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In ten out of ten psychiatric assessments reviewed (100%), there was specific evidence that clearly delineated a review of non-pharmacological interventions 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 eight out of ten examples (80%), the case formulation for the psychiatric assessment utilized data, and data analysis derived by the annual psychology assessment.

Based upon information made available by the Facility, it was apparent that the Facility had not maintained previous progress.
</td><td></td></tr>
<tr><td>K6</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.</td><td>
According to information obtained from the review of the sample presented in K.5, the following conclusions were reached.

Intelligence tests had been completed within the past five years for 64 of 66 individuals (97%).
Testing of adaptive skills had been completed in under one year for 10 of 66 individuals (15%).
Psychological evaluation reports had been completed in under one year for 45 of 66 individuals (68%).

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>Noncompliance</td></tr>
<tr><td>K7</td><td>Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.</td><td>
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>Baseline</th><th>11/2013</th><th>5/2014</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>66%</td><td>68%</td></tr>
<tr><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>89%</td><td>17%</td><td>100%</td></tr>
</table>
Since the previous site visit, the Facility admitted four individuals (Individuals #7, #38, #62, and #103). Tracking data provided to the Monitoring Team for Individuals #38, #62, and #103 and the admission Behavioral Health Assessment for Individual #7
</td><td>Noncompliance</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>revealed the following details.
4. Two of four individuals (50%) had been provided an assessment of adaptive skills. Although the admission Behavioral Health Assessment for Individual #7 provided an Adaptive Behavior Level, it gave no information about specific adaptive behaviors or areas of strength and need.
5. Four of four individuals (100%) had been provided an assessment of intellectual ability.
6. Four of four individuals (100%) had assessments compiled and interpreted within a written assessment report.

Although substantially improved since the previous site visit, based upon available documentation psychological assessments were not based upon complete clinical and behavioral data.</td><td></td></tr>
<tr><td>K8</td><td>By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.</td><td>No individuals living at RGSC at the time of the site visit were participating in counseling, psychotherapy, or any psychological service other than a PBSP. There was no indication in documents provided to the Monitoring Team that this was reviewed for any individual by the IDT or that counseling or other psychological services other than PBSPs had been considered.</td><td>Noncompliance</td></tr>
<tr><td>K9</td><td>By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility</td><td><u>PBSP Approval and Consent</u>
<u>Historical Perspective</u>
At the time of the baseline visit, 78% of individuals sampled were provided with adequate consents. By March 2012, this had dropped to 36% of individuals sampled. 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.

<u>Current Site Visit</u>
During the current site visit, the Facility tracking spreadsheet was used to determine the status of PBSP consents. The documentation reflected that for 40 of the 58 PBSPs requiring consent (69%), the appropriate and current consents had been obtained.

<table><tr><th></th><th>Baseline</th><th>11/2013</th><th>5/2014</th></tr><tr><td>Necessary consents and approvals are obtained for each PBSP and safety plan prior to implementation.</td><td>78%</td><td>76%</td><td>69%</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	Superintendent may grant a written extension based on extraordinary circumstances.	Specific weaknesses regarding approvals and consents included the following. • Peer Review was over a year old for 18 of 58 PBSPs (31%). • Guardian consent was over a year old for 16 of 58 PBSPs (28%). A review of Facility tracking data also reflected that RGSC experienced difficulty in implementing PBSPs promptly after approval and consent were obtained. For 42 of 58 active PBSPs (72%), there was a delay of greater than 14 days between consent and implementation. The average noted delay was 42 days. <u>PBSP Review</u> During the current site visit, the Monitoring Team selected a sample of 10 individuals for the review of PBSPs. These individuals included individuals with recent ISPs. The specific individuals included in the sample were Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. Documentation was requested from the Facility for these 10 individuals on three occasions. The Facility failed to provide documentation for three individuals (Individuals #55, #77, and #98).	

PBSP Element	Baseline	11/2013	5/2014
Rationale for selection of the proposed intervention	0%	100%	70%
History of prior intervention strategies and outcomes	0%	100%	0%
Consideration of medical, psychiatric and healthcare issues	0%	100%	70%
Operational definitions of target behaviors	0%	100%	70%
Operational definitions of replacement behaviors	0%	100%	70%
Description of potential function(s) of behavior	0%	100%	70%
Use of positive reinforcement sufficient for strengthening desired behavior	0%	100%	70%
Strategies addressing setting event and motivating operation issues	0%	100%	70%
Strategies addressing antecedent issues	0%	100%	70%
Strategies that include the teaching of desired replacement behaviors	0%	100%	70%
Strategies to weaken undesired behavior	0%	100%	70%
Description of data collection procedures	0%	100%	0%
Baseline or comparison data	0%	100%	70%
Treatment expectations and timeframes	0%	100%	70%

<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>written in objective, observable, and measureable terms</td><td></td><td></td><td></td></tr>
<tr><td>Clear, simple, precise interventions for responding to the behavior when it occurs</td><td>0%</td><td>100%</td><td>70%</td></tr>
<tr><td>Plan, or considerations, to reduce intensity of intervention, if applicable</td><td>0%</td><td>100%</td><td>0%</td></tr>
<tr><td>Signature of individual responsible for developing the PBSP</td><td>0%</td><td>100%</td><td>70%</td></tr>
</table>

If the table above were based only upon the documentation provided for the seven individuals, the percentages would be the same as those reported during the previous site visit, except for declines in presenting history, describing data collection procedures, and describing a plan or considerations to reduce intensity of the intervention. As three requests were made of the Facility for the necessary documentation, it can only be presumed that the requested documentation did not exist.

As reported in Provision K4, the PBSP for Individual #77 was available at the peer review meeting observed by the Monitoring Team, although not provided in response to the document request. Review of this PBSP would not have resulted in an improvement in overall ratings. Therefore, the Monitoring Team cannot conclude that the standards found at 70% were met consistently across the requested sample.

It should be noted that Provision J8 reports, from a review of a different sample of individuals receiving pharmacological therapy, that the PBSPs consistently documented appropriate behavioral indices of psychopathology to measure.
</td><td></td></tr>
<tr><td>K10</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic</td><td>
<u>Current Site Visit</u>
During the current site visit, the Monitoring Team selected a sample of 10 individuals for the review of data collection and treatment monitoring. These individuals included individuals with recent ISPs. The specific individuals included in the sample were Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. Documentation was requested from the Facility for these 10 individuals on three occasions. The Facility failed to provide documentation for two individuals (Individuals #77 and #98).

The table below reflects the results from the current site visit review regarding the collection and presentation of data.
<table>
<tr><td>Graph Element</td><td>Baseline</td><td>11/2013</td><td>5/2014</td></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>0%</td><td>100%</td><td>80%</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>medications.</td><td>
<table>
<tr><td>Horizontal axis and label</td><td>0%</td><td>100%</td><td>80%</td></tr>
<tr><td>Vertical axis and label</td><td>0%</td><td>83%</td><td>80%</td></tr>
<tr><td>Condition change lines</td><td>0%</td><td>100%</td><td>80%</td></tr>
<tr><td>Condition labels</td><td>0%</td><td>100%</td><td>80%</td></tr>
<tr><td>Data points and path</td><td>0%</td><td>100%</td><td>50%</td></tr>
<tr><td>IOA and data integrity</td><td>0%</td><td>33%</td><td>0%</td></tr>
<tr><td>Demarcation of changes in medication, health status or other events</td><td>0%</td><td>100%</td><td>10%</td></tr>
</table>
In ten out of ten records, either progress notes were not available or a substantial number of progress notes reflected that IOA had not been assessed. This lack of consistent reliability measures reflected that the Facility had regressed since the previous 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>Baseline</td><td>11/2013</td><td>5/2014</td></tr>
<tr><td>IOA for target behavior data.</td><td>0%</td><td>33%</td><td>0%</td></tr>
<tr><td>IOA for replacement behavior data.</td><td>0%</td><td>17%</td><td>0%</td></tr>
<tr><td>IOA meets minimum criteria</td><td>0%</td><td>17%</td><td>0%</td></tr>
</table>
Based upon the information obtained during the current site visit, the Facility demonstrated considerably poorer ratings in comparison with the previous site visit. If the table above were based only upon the documentation provided for the seven individuals, the percentages would be the same as those reported during the previous site visit. As three requests were made of the Facility for the necessary documentation, it can only be presumed that the requested documentation did not exist. Therefore, it was determined that the inclusion of all 10 individuals was the most accurate representation of compliance by the Facility.
</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 used the Facility spreadsheet for tracking peer review to determine readability ratings. For the 27 PBSPs reviewed since the previous site visit, the average readability score was grade 7.8, which was satisfactory.</td><td>Substantial Compliance</td></tr>
<tr><td>K12</td><td>Commencing within six months of the Effective Date hereof and with full implementation in two years,</td><td>The Facility provided a tracking spreadsheet for PBSP trainings. Based upon the dates on the spreadsheet, staff trainings were conducted only following the initial implementation of the PBSP. The tracking spreadsheet also indicated those staff required to be trained on</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>each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.</td><td>a PBSP, as well as whether those staff had been trained.

The spreadsheet used at the Facility to track PBSPs reflected that 26 PBSPs had been implemented since the previous site visit. The spreadsheet for tracking PBSP training, however, reflected that training had been provided for only 14 PBSPs since the previous site visit. For each of those 14 PBSPs, the table below reflects the number of staff who were required to have training, as well as the number of staff that actually received training.

<table>
<tr><th>Individual</th><th>Staff Requiring Training</th><th>Staff Trained</th><th>Percent of Required Staff Trained</th></tr>
<tr><td>2</td><td>32</td><td>15</td><td>47%</td></tr>
<tr><td>6</td><td>42</td><td>22</td><td>52%</td></tr>
<tr><td>28</td><td>42</td><td>13</td><td>31%</td></tr>
<tr><td>31</td><td>42</td><td>22</td><td>52%</td></tr>
<tr><td>35</td><td>16</td><td>4</td><td>25%</td></tr>
<tr><td>45</td><td>42</td><td>18</td><td>43%</td></tr>
<tr><td>60</td><td>43</td><td>21</td><td>49%</td></tr>
<tr><td>62</td><td>41</td><td>7</td><td>17%</td></tr>
<tr><td>65</td><td>42</td><td>17</td><td>40%</td></tr>
<tr><td>76</td><td>42</td><td>7</td><td>17%</td></tr>
<tr><td>103</td><td>44</td><td>17</td><td>39%</td></tr>
<tr><td>115</td><td>44</td><td>16</td><td>36%</td></tr>
<tr><td>119</td><td>16</td><td>5</td><td>31%</td></tr>
<tr><td>131</td><td>40</td><td>20</td><td>50%</td></tr>
</table>

Based upon the discrepancy between the PBSP tracking spreadsheet and the training spreadsheet, as well as the limited number of staff trained, there was little indication that the staff tasked with implementing PBSPs were adequately prepared to perform that task. Furthermore, as no additional training documentation was provided, 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 (CBT) for all staff working with a particular individual.</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		• The Facility did not present a measure or system for assessing the competence of staff in relation to challenging behaviors that occur infrequently.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the site visit, the Facility employed two staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 33 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 1:33 ratio, which was the current ratio. Given the small number of residents, one additional BCBA would well exceed this requirement. Therefore, the Monitoring Team finds this substantially complies with the requirement. 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 (5/7/2014) 2. RGSC Action Plan (5/7/2014) 3. Presentation Book, May 2014 4. RGSC Standard Operating Procedure ICF-IID 400 14; Medical Care, dated November 2004, revised July 2013 5. DADS Policy: Medical Provider External/Internal Audits, revised July 6, 2012 – no number 6. RGSC Standard Operating Procedure, ICF-IID 400 19; Minimum Common Elements of Care, January 2014. 7. Copy of reports, data and summaries for round 8, internal and external medical audit reports 8. Document by the Facility indicating that results of internal and external medical audits were not discussed with the medical provider, and were not incorporated into the peer review process 9. List of all medical providers, including number of hours worked, case load, and employment status 10. For each medical provider a. Curriculum vita for all licensed medical providers b. Copy of current medical license for two medical providers c. Copy of current CPR certificate for all medical providers (the Monitoring Team requested all but received two) d. List of all CME obtained during the past 12 months for all medical providers 11. Copy of morning medical meeting minutes for the first meeting of each month during the reporting period 12. List of all individuals who were prescribed a DNR order 13. Community Living Discharge Plan (CLDP), and active clinical record for Individual #149 14. Active clinical record, trigger sheet, and physical and nutritional management plan (PNMP) for Individual #126 15. Active clinical record for Individuals #5 and #29 16. For Individuals #65, #139, #131, #2, #63, #108, #85, #127, #36, and #11 a. Copy of all medical consultation reports specific to the management of the acute medical condition b. Provider's IPNs, specific to the initial evaluation, and all subsequent follow-up IPNs through full resolution of the acute medical condition c. Copy of all related diagnostics specific to the evaluation and follow-up of the acute medical condition 17. Document stating that there were no bowel obstructions or perforations during the reporting period 18. Alpha list of all individuals with diagnosis of CP 19. Alpha list of all individuals with implanted Baclofen pump 20. Alpha list of all individuals screened for possible need of a Baclofen pump 21. For Individuals #115, #85, #143, 19 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 22. Alpha list of all individuals who sustained a fracture during the reporting period 23. Committee meeting minutes, and all other relevant documents indicating a Facility systems review of fractures, and attempts to mitigate fractures 24. For all individuals who had a long bone or axial fracture, please provide the following (individuals #72, #65, and #84): 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 25. List of all individuals with diagnosis of malignancy 26. For Individual #150: a. Most recent annual medical summary b. All consultations and associated diagnostics specific to the diagnosis of malignancy c. Most recent IRRF, and all ISP meeting minutes addressing the diagnosis of malignancy 27. Alpha list of all individuals with a diagnosis of osteoporosis 28. For Individuals #79, #98, #19, #21, and #5: 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 29. List of all individuals with diagnosis of pneumonia during this reporting period 30. Document stating that there are no individuals known to have recurrent pneumonia

	31. For Individual #33: a. ISP, and addendum to ISP specific to the diagnosis of pneumonia b. Physical and Nutritional Management Team (PNMT) meeting minutes, dated 12/3/2013 c. Most recent annual medical summary, dated 4/4/2014 i. Physical and occupational therapy assessment (PT/OT), dated 3/10/2014 **People Interviewed:** 1. Dr. David Moron, Clinical Director **Meeting Attended/Observations:** 1. Medical Morning Meeting, 5/21/2014 2. Individual Support Plan (ISP) Meeting for Individual #126, 5/20/2014 3. Observation at living areas 05/19/2014 through 5/22/2104
	Facility Self-Assessment: Following its review of the self-assessment for Section L, the Monitoring Team noted that the Facility: • Did not use monitoring/audit tools that relied on sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement. • The monitoring tools did not include sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes. For example, there were no standards of care or clinical indicators documented to assess the provision of medical services. • The Self-Assessment did identify the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall. The sample sizes were adequate to consider them representative samples. The number or percent of sample size of individuals/records as compared to the overall population was included in the Self-Assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was not provided by months, quarters, but just overall percentage of compliance. • The Monitoring Team could not determine if the Facility's monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results through inter-rater reliability process completed by the QA department. ▪ It was unknown to the Monitoring Team if sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools. The Facility determined that it was not in compliance with Sections L.1 through L.4, and the Monitoring Team concurred with this assessment.
	Summary of Monitor's Assessment: There were several areas of improvement in medical care, but there were also areas in which no improvement had occurred. The Facility has had difficulty in retaining primary care physicians, which makes continuing improvement difficult. The Facility had one full-time staff and one contract physician; the contract physician was in process of being employed as staff. The Monitoring Team concurs with the Facility's determination of noncompliance with Sections L.1 through L.4.

	The Facility had significantly improved the medical management of acute medical conditions. The Facility was noted to have continued issues with regards to following up on medical conditions, medical providers' participation at IDT meetings, and ensure all relevant medical issues were included in annual ISPs. A recent CLDP lacked attention to many important clinical issues, including necessary monitoring and reporting parameters. 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:** There was significant improvement with regard to updating medical diagnosis, and better ensuring that acute and chronic medical conditions are identified and treated; further progress needs to be made. A continued significant area of deficiency was noted in incorporating medical issues and plans to address those into the interdisciplinary team process. Medical diagnoses, necessary treatments, medical follow-up, important monitoring and reporting parameters, and all necessary supports and services provided for each medical condition were not addressed on the annual medical summary, ISP, or IRRF, and not all were addressed at the ISP meeting. Although, in general, acute medical issues were initially triaged by the medical provider, there was no evidence of consistent follow-up by the medical provider through full resolution of the acute condition. Furthermore, there was no evidence provided to demonstrate the medical providers regularly review underlying causative factors of medical conditions. The Monitoring Team would like to emphasize the importance of comprehensive, interdisciplinary care for all medical conditions. **Section L.2:** The current external medical provider audit process did not utilize findings from the review within the context of a peer review process, by reviewing the results directly with the medical provider. There was no evidence provided to indicate that action plans were completed, or to assess action plans for efficacy. Furthermore, the audit process did 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, if appropriate medical supports and services are efficacious or, if not, that the medical provider reconvenes with the IDT to further develop strategies that will enhance clinical outcome. For these reasons, the Monitoring Team determined noncompliance with Section L.2. **Section L.3:** As with the external medical audit, the internal medical audit process did not utilize findings from the review within the context of a peer review process, by reviewing the results directly with the medical provider. There was no evidence provided to indicate that action plans were completed, or to assess action plans for efficacy. Furthermore, the audit process did not adequately assess clinical performance of the medical providers but focuses mostly on process. For these reasons, the Monitoring Team determined that the Facility is not in compliance with Section L.3. **Section L.4:** The Facility had not substantially implemented its standard operating procedure for health care, or developed and implemented essential policies and procedures to ensure that medical care is consistent with generally accepted professional standards of care. One improvement is that Standard

	Operating Procedure, Minimum Common Elements of Care calls for the development and implementation of clinical pathways for 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.	Section 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 Section L.1, the Monitoring Team discussed medical compliance issues with the medical director; met with members of the Facility's medical staff; and attended medical meetings, and an annual ISP planning meeting. Through document review, the Monitoring Team assessed the Facility's medical administration; physician participation in completion of a community living discharge plan; practice for do not resuscitate orders; clinical management of acute medical conditions; and management of seizure disorder and Vagal Nerve Stimulators, recurrent pneumonia, osteoporosis, management of fractures, 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 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 full time staff physician, and one full time contract physician. The clinical director provided administrative services only, and did not provide direct clinical care; hence, the Facility maintained two 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		one of the two medical providers who provide direct care. There was no evidence of CME being provided for specific clinical issues related to intellectual or developmental disabilities. Summary: The Facility continued to maintain adequate medical staff to support the health care needs of individuals who reside at the Facility. <u>Medical Meetings</u> The Facility conducted a daily Morning Medical Report meeting five days per week. Participants include medical providers, unit nursing staff, and representatives from various departments, including PT/OT, behavioral health, residential services, psychiatry, dietary services, and quality assurance. The purposes of the meeting are to 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, infectious disease issues, and significant medical conditions. Review of the meeting minutes for the Morning Medical Report meetings that occurred on the first Monday of each month, beginning 11/2013 through 4/2014 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 noted these same findings at the last compliance visit, and the same issues were documented on the last report. The Monitoring Team attended the morning medical meeting on Wednesday, 5/21/2014. The meeting demonstrated a full complement of disciplines, including physician, nursing, PT/OT, psychology, and habilitation staff. The Monitoring Team did not observe assertive interdisciplinary interaction when discussing clinical cases, and in general, the meeting functioned more like a report of what transpired on the previous day. For example: 4. An individual was reported to have sustained a fractured tooth, and there was no discussion about how the tooth was fractured, what may have precipitated the fractured tooth, and determination if additional supports and services were necessary. 5. It was reported that an Individual had refused medication, and there was no discussion to determine if the medication had eventually been administered, the reason for the medication refusal, and what, if any supports may be needed to assist the Individual in taking medication. 6. An Individual, who is known to have significant medical issues, was reported to have fallen on the floor, and there was no discussion to determine if a medical assessment	

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		had been completed to help rule out possible injury. Given the complex medical condition of this Individual, a medical examination to assess for possible injury would be appropriate. 7. There was no observational evidence indicating that the morning medical meeting reviewed or followed up on past reported incidences. For example, if a clinical issues was raised, and members of the morning medical meeting recommended a specific treatment, diagnostic or follow-up, such an issue should be followed up on to ensure completion and expected outcome from the intervention. Summary: As per the last compliance review by the Monitoring Team, it was determined that the morning medical meeting communicated information but did not provided meaningful clinical review, did not function in an interdisciplinary manner, and did not demonstrate follow-up to previous reported issues. <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 provider's interdisciplinary progress notes (IPN) documenting the clinical rationale for the DNR The Facility provided a written document stating that no individuals at the Facility were considered to be DNR. The Facility did provide a recently updated draft version of a DNR policy for review: RGSSLC Standard Operating Procedure FW 106-16, revised 03/2014, which was implemented on the last day of the Monitoring Team's compliance visit, 5/23/2014. 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	

#	Provision	Assessment of Status	Compliance
		all policies, procedures, and ethics review process at the next compliance visit. It should be noted that on the last day of the compliance visit the Monitoring Team was informed that the Facility was assessing an Individual for a possible partial DNR, secondary to underlying medical conditions that could complicate resuscitation. <u>Review of Community Living Discharge Plans:</u> To assess the medical providers participation in the development of CLDPs, the Monitoring Team reviewed one of two (50%) CLDPs developed during the review period. The following are some concerns and suggestions, specific to the CLDP review for Individual #149: • The Individual was prescribed calcium supplements, and the CLDP did not comment on the need to administer this medication at a separate time as the levothyroxine is administered. The manufacturer of the levothyroxine recommends a four-hour window between dosing levothyroxine and calcium supplements. There was no essential support listed to administer levothyroxine 30 minutes prior to eating or taking other medications prior to the first meal, upon awakening, or to train provider staff on the individual's medication administration requirements. The provider will need information that can be given to staff so this is done from the first day of transition, and the Post-Move Monitor will need to know to check that this is occurring. • The medical diagnosis listed on the physical description section of the CLDP, dated 3/27/2014, did not list a diagnosis of hypothyroidism, under the subsection of medical diagnosis; however, the active problem list under section III of the CLDP stated hypothyroidism as a diagnosis. This ambiguity could lead to miscommunication of the Individual's health care issues. • Section II of the CLDP did not list a dentist or dental office, as necessary to provide on-going dental services. The PMM documented that a dental appointment must be obtained by 7/10/2014. Oral health care is an important component of the individual's healthcare plan, and identifying a dentist who will assume care of the Individual should be considered as a necessary, pre-move criterion. • The physical examination component of the CLDP documented that there was cerumen impaction of the ears; that the Individual had a diagnosis of sensorineuro hearing loss due to chronic infections, and perforated tympanic membrane; is prone to ear infections; and was recommended by the ENT specialist to use a hearing aid. There was no documented evidence provided that indicated the cerumen had been removed prior to transition, and given the history of hearing impairment, recurrent otitis, history of cerumen impaction, and hearing loss, the Monitoring Team had expected to find a plan delineating	

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		monitoring and reporting parameters for ear infections, and worsening hearing loss, and to periodically assess for cerumen impaction. Also, identification of a hearing specialist who would regularly follow up on this condition should have been listed as a support needed, and a specialist should have been obtained so that a Facility clinician could discuss the issue with the provider prior to transfer from the Facility. • The physical examination component of the CLDP indicated that the Individual had a low heart rate of 53, which met diagnostic criteria for bradycardia. This issue was not further addressed in the CLDP, and there was no medical plan developed for further evaluation of this issue, or for the agency to closely monitor this condition and train staff in indicators to observe and report. • The physical examination component of the CLDP (a document titled "Discharge Summary and Annual Update") indicated that the chest was "deferred" and the breast, genitourinary and rectal examination were delegated to an external medical provider, however, the CLDP did not include the results of the external medical provider's findings for this component of the physical examination. To help ensure that all medical conditions had been identified and information is accessible to the new provider, and that necessary supports and services put in place, all components of the physical assessment should be completed prior to transfer from the Facility and not reported as deferred, and information is included from any assessment delegated to an external physician. • The Individual was prescribed a weight maintenance diet. The CLDP included a support to weigh the individual monthly and to report significant weight changes but did not provide specific weight range or weight change parameters to trigger a report. It is important for the community agency to be informed of reasonable monitoring, and reporting parameters for weight loss, and gain. The parameters should be specific for the individual, and developed to identify potential clinically meaningful changes in weight. Summary: There were several medical issues, including the need for a genitourinary, rectal and breast examination, and the need for cerumen disimpaction prior to transfer from the Facility; there was no evidence that these issues were addressed. The CLDP should ensure that specific monitoring parameters are developed for necessary clinical monitoring to provide guidance for the post move monitoring assessment. For example, given that this Individual was on a weight management diet, a specific weight range should have been identified, and PMM staff should determine whether the provider assesses weight and reports changes based on an appropriate schedule identified in the CLDP. Also, because this Individual has criteria for bradycardia, the medical provider should have evaluated the etiology of the bradycardia, and at a minimum, specific monitoring and reporting parameters should have been developed for monitoring by the	

#	Provision	Assessment of Status	Compliance
		provider agency. Necessary consultations, such as follow-up for dental services, and in this particular case, follow-up with a hearing specialist, this should have been arranged prior to transfer from the Facility, and determined to be a required support. Observation of Individual Support Plan Meetings The Monitoring Team attended the ISP meeting for Individual #126 on Tuesday, 5/20/2014, and reviewed the active clinical record, most recent PNMP, and the most recent trigger sheet. The following is a detailed review that delineates the Monitoring Team's concerns with the Facility's ISP process: • The Individual was known to have significant degenerative spine disease, associated myelopathy, and was post cervical spine surgery to stabilize the cervical spine: o The issue of degenerative spine disease was not addressed at the ISP meeting. Issues such as specific monitoring and reporting parameters for worsening myelopathy and pain should have been addressed at the IDT meeting but was not. Information about this, and any actions to be taken, should have been reflected in prior ISPs, IRRFs, and IHCPs. o Staff reported at the ISP meeting that the Individual is regaining functional ability; however, there was no report or other indication that routine functional assessments, including range of motion measurements and assessment of deep tendon reflexes, were completed. o There was no comment on the Individual's known degenerative disease of the lower spine or of action plans to address this. • There was no evidence to indicate that pain was routinely assessed by an individualized assessment. This Individual is at risk for significant pain, as evident by underlying medical pathology, including esophagitis, gastritis, possible constipation, and significant degenerative spine disease. The Monitoring Team is concerned that the IDT did not assertively review all potential causes of pain, did not ask to review assessments for of pain, but concluded that the Individual did not experience pain. Furthermore, before discussing risk factors for pain, some members of the IDT did indicate that the Individual manifested maladaptive behaviors prior to bowel movements; however, this issue was not further explored when the IDT was reviewing the risk rating for pain. o The medical provider documented a detailed IPN, dated 4/9/2014, indicating that the IDT must ensure appropriate clinical targets are identified before analgesics can be administered. o On 4/9/2014, the BCBA was notified to evaluate the Individual to assess for maladaptive behaviors when transferring. The BCBA reported that the behaviors were most probably associated with an underlying	

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		medical condition, and recommended that a medical evaluation be provided. Upon review of the active record, review of medical provider's IPNs, and discussion with the BCBA, the Monitoring Team found no evidence to indicate that a medical assessment was done to evaluate for underlying medical causes resulting in maladaptive behaviors. • The Individual was recently evaluated by a pulmonologist for infiltrates noted on chest x-rays. Following a bronchoscopy it was determined that the Individual had positive cultures for fecal bacteria, E. coli, and streptococcus. The medical provider, at the ISP meeting, stated that the Individual had aspiration pneumonia; however, other members of the IDT indicated that the diagnosis of pneumonia could not be made because the Individual did not meet the Facility's criteria for pneumonia, and therefore, despite being treated for pneumonia, should not be diagnosed with pneumonia. Given that there was an active infiltrate, and positive cultures by bronchoscopy, the diagnosis of aspiration should have been further entertained. The Monitoring Team refers the reader to Section L.4 of this report for additional concerns specific to the Facility's policy for diagnosing pneumonia. • The Individual had experienced long-term "stool seepage", which resulted in perianal skin breakdown. The etiology of the stool seepage was not clearly delineated at the IDT meeting; however, it was reported that the perianal skin breakdown had resolved. It was also stated that the Individual did not have constipation, but after discussion it was determined to raise the IRRF rating for constipation to medium because the individual was "immobile". No further discussion about constipation was discussed at the IDT meeting, and there was no diagnosis of constipation in the active problem list. The Monitoring Team is concerned that the IDT did not consider the following clinical issues, as possible risk factors for constipation, or the need to further evaluate for constipation and possible gastroparesis: o It was reported that the Individual manifests self-injurious behaviors about 30 minutes prior to having a bowel movement. o The Individual has had a long-term history of "stool seepage" with soft stools. o Following a surgical consultation, the surgeon diagnosed normal rectal tone, and "overflow incontinence". Overflow incontinence usually indicates an obstruction, which could be retained stool. o The Individual has a diagnosis of myelopathy, which can put the Individual at risk for constipation. o An x-ray, dated 2/6/2014, indicated that the colon had retained stool. Retained stool can be an indication for constipation, and consideration should be given for such a diagnosis.	

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		○ The Individual was reported to have experienced a recent history of frequent emesis, that was reported to have resolved, and was secondary to tube feeding issues; however, the Monitoring Team could not find evidence to support a medical evaluation for recurrent emesis, especially an evaluation for possible gastroparesis. Given the Individual's complex disabilities, including myelopathy, multiple risk signs suggestive of constipation, and bronchial cultures indicating fecal contamination in the lungs, an evaluation for gastroparesis, as well as other causes of constipation, should have been done, or at least entertained at the ISP meeting. Furthermore, following the ISP meeting, the Monitoring Team learned that the Individual had additional recent episodes of emesis. ○ The Individual had an adenotomous polyp removed and was reported to be at risk for colon cancer. Constipation can be a manifestation of colon cancer. ○ Following a colonoscopy, the Individual was diagnosed with internal hemorrhoids; however, this issue was not included as a diagnosis. • The issue of aspiration and choking was raised by the IDT; however, the discussion focused on dysphagia, and there was no meaningful discussion about possible risks associated with regurgitation. The active clinical record did not indicate a diagnosis of GERD, despite the following known clinical conditions: ○ History of recurrent emesis ○ Recent history of positive bronchial cultures for E. Coli ○ Documented hiatal hernia on EGD report, listed as a historic diagnosis on the annual medical assessment ○ EGD report indicating esophageal stricture, and status post balloon dilation ○ Documented Schatzki Ring, causing stricture and balloon dilation, per an EGD report. The condition was listed as a historic diagnosis on the annual medical assessment. Unless surgically removed, Schatzki Rings are persistent, and these call for periodic swallowing assessment with esophagram or alternative diagnostics. ○ Enteric tube nutrition and hydration. • Given the diagnosis of significant degenerative spine disease, myelopathy, recurrent emesis, and risks associated with GERD, the Monitoring Team was concerned that specific assessments, as well as periodic observational monitoring of transfers, bathing, and ambulation were not documented, using a standardized assessment format. Specific assessments should be routinely completed to ensure that provided services are performed appropriately, are efficacious, and do not cause harm. For example, the IDT	

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		members were unable to inform the Monitoring Team if a two-person lift, or the use of a hydraulic lift, was in the best interest of the Individual. Also, there was no indication that a medical evaluation was completed to ensure that the Individual's musculoskeletal system could safely support pivot transfers and ambulation, which were being provided by staff. Following discussion with the Monitoring Team, the IDT indicated that an assessment would be developed to ensure that the appropriate means for transfers and bathing would be developed. In general, when used appropriately, hydraulic lift is more effective and safer than a two-person lift. • The PNMP stated, "staff to utilize mechanical lift (when necessary) for safety, and to minimize injury". As noted above, the Monitoring Team is concerned that there were no assessments as to the safest means for transfer. In addition, there were no criteria developed to inform staff when to use and not use a hydraulic lift; direct care staff must be specifically instructed when, and when not to apply a clinical support. • Given the known significant risks for aspiration, the Monitoring Team is very concerned that the PNMP for positioning stated "during personal care, head of bed may be flat for a few minutes ONLY entire bed should be raised at optimal level to the staff". Any time, and for any duration of time, that a person with documented risk factors for aspiration is in a flat position, the individual is at risk for aspiration. • During the ISP meeting, the issue of DNR was raised very briefly by stating that the Individual did not have a DNR. There was no meaningful discussion to determine the possible need for a DNR, or partial DNR. When a DNR can potentially cause do harm, such as when performing chest compressions outweighs possible benefits, consideration for no chest compression DNR should at least be discussed by the IDT. In this situation, the Individual has known cardiac conditions that, as reported by the cardiologist, may exacerbate secondary to the Individual's aging process; significant degenerative spine disease; history of multiple and bilateral rib fractures; and known aspiration risks. Therefore, the risks and benefits of chest compressions and intubation should have been discussed by the IDT. • The Individual has several infectious disease risks, including hepatitis infection, H. Pylori infection, and known respiratory pathogens. Infection control practices were not assertively assessed by the IDT. H. Pylori infection, and associated emesis, have a high propensity for transmitting H. Pylori to others, and there was no discussion as to the effectiveness of precautions employed by the Facility to ensure that infection control practices were in place to meet the clinical needs of the Individual. • The Individual has known cardiac disease, that includes congenital	

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		anomalies, and valve disease, and the IDT did not develop specific monitoring and reporting parameters for staff. Review of the active clinical record indicated that the condition had been routinely assessed by a cardiologist, and was currently stable; however, the cardiologist warned that given the Individual's age, the Individual's cardiac condition could worsen. • Following a colonoscopy, and as reported on the GI consultation report dated 5/21/2013, the individual was noted to have had an adenomatous colon polyp removed, and is at increased risk for colon cancer, and requires follow-up colonoscopy in 2018. The issue of increased risk for colon cancer was not addressed at the ISP meeting. The IDT should have discussed the issue of increased risk for colon cancer, and need for close monitoring. • This individual, who has a known diagnosis of hiatal hernia, aspiration risks, esophagitis, known esophageal stricture, positioning issues, and gastritis, was prescribed and administered a medication, alendronate, that is contraindicated in individuals with esophageal stricture, aspiration risk, and inability to sit upright for 30 minutes; its use is cautioned in Individuals with upper GI disease, such as esophagitis and gastritis. The Monitoring Team did identify a medical provider's IPN, dated 4/2/2014, indicating that the Individual was on alendronate, and that this medication should be discontinued. In addition, the Individual was currently being administered daily aspirin; daily aspirin can lead to worsening gastritis, esophagitis, and lead to potential ulceration and perforation in this case. This issue should have been reviewed at the ISP, and the IDT should have reviewed the Individual's osteoporosis, and associated risks and benefits of treatment for osteoporosis. Furthermore, in the most recent two quarterly drug regimen reviews, the clinical pharmacist had indicated "Pt has a hx of multiple fractures and is appropriately being treated with Fosamax 70 mg weekly with Vit. D supplementation". The Monitoring Team is very concerned that the QDRR did not identify associated risks for the use of Fosamax (alendronate) and aspirin usage. The medical provider should have brought this to the attention of the IDT for discussion of risks and benefits. • Review of medical plans documented on the most recent annual medical assessment indicated they were not adequate to reflect specific medical treatment, necessary follow-up, monitoring and reporting parameters for the medical condition, and all necessary services required to support that Individual at the Facility. Summary: There were many instances noted in the active medical record that indicated efficacious	

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		medical management such as congenital heart disease, follow-up to abnormal laboratory results; follow-up on medical consultation reports; and treatment of active medical problems, such as pneumonia, among other medical interventions. This review focuses specifically on the ISP meeting and the IDT involvement, and understanding of the Individual's medical concerns. The Facility continues to demonstrate less than effective interdisciplinary review and discussion of medical conditions, which results in a lack of appropriate supports and services that are necessary to ensure adequate healthcare. The purpose of the ISP is to ensure that all relevant issues, including issues directly related to healthcare, are well communicated among the IDT members to ensure that all medical treatments and follow-up issues are clearly documented; specific monitoring and reporting parameters are developed and implemented so direct care staff are aware of specific issues that must should be routinely monitored; and that all necessary services are provided, and are efficacious, for each medical condition. The Facility needs to implement processes that address these requirements. <u>Individual Case Reviews</u> The Monitoring Team reviewed the active clinical record for Individuals #5 and #29. Individual #5: Review of the active clinical record indicated that the Individual had known diagnosis of osteoarthritis of the hip, abnormal gait, dysphagia, myotonia with lax joints, and diabetes, among other medical diagnoses. Axis I diagnoses included mood disorder with psychosis, intermittent conduct disorder, and obsessive compulsive disorder. The Individual was noted to be on polypharmacy that included haloperidol, Benztropine, and topiramate, among other drugs. Review of the current IRRF indicated that the Individual had sustained 17 falls, and indicated a risk factor of High, for falls, fractures, osteoporosis, and diabetes. The IRRF did not consider polypharmacy as a potential risk factor or contributing risk factor for falls, did not document haloperidol as a risk factor for osteoporosis, and did not document the potential risk of glucose intolerance associated with Haldol. The diagnosis listed on Axis I of the acute problem list of intermittent conduct disorder, was not consistent with a DSM diagnosis. Review of the most recent annual medical assessment, dated 12/20/2013 resulted n the following concerns: • The individual has significant risk factors for falls; however, known fall risks such as polypharmacy, abnormal gait, and myotonia, among other diagnoses, were not delineated, or otherwise indicated as issues of clinical concern, on the	

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		review of symptoms in the annual medical assessment. Abnormal gait and associated falls should have been listed under review of systems, and a specific action plan developed to address this issue. • Medical action plans were vague, and did not delineate a clinically relevant plan that medical services would need to follow, and did not list necessary supports and services. For example, there was no explanation as to the etiology of the diagnosis of abnormal gait. A medical workup should have been completed and the etiology, or at a minimum a differential diagnosis, should have been developed for this condition. For the diagnosis of myotonia with loose joints, the medical provider documented "stable at this time"; there was no consideration as to this condition possibly contributing to the high number of falls, and there were no supports and services listed for this condition. For the diagnosis of osteoarthritis of the hip, the medical provider documented "will continue to monitor that situation"; there was no plan provided for periodic medical follow-up, assessment for pain, or other necessary supports and services for this condition. • For the diagnosis of osteoarthritis of the hip, the medical plan indicated "will continue to monitor that situation". The only diagnostic imaging study observed in the clinical record was a hip x-ray from 12/4/2012 that demonstrated moderately advanced degenerative joint disease; however, there was no indication that this condition we regularly assessed for possible worsening, or for associated pain and/or loss of function. There was no indication that the individual had followed up with a medical specialist. • The Individual was reported to have a diagnosis of unspecified intestinal malabsorption, but there was no documentation as to the etiology, or indication that a clinical work-up had been completed, including a differential diagnosis for the malabsorption. The medical plan did not specify necessary supports and services, other then "monitoring is being done through laboratory work". • The quarterly medical review, dated 5/10/2014, did not assess issues such as falls and fall risks, unsteady gait, nutritional assessment for malabsorption, or worsening osteoarthritis and associated pain. The medical provider should ensure that all known and suspected medical conditions are evaluated as to the etiology of the condition; and ensure that all necessary medical treatments, diagnostics, and necessary supports and services are identified, implemented and assessed for efficacy in the management of the condition. Possible contributing issues, such as underlying medical conditions and medications should be included as potential at-risk conditions. Individual #29: Review of the most recent IRRF assessment, dated 2/4/2014, indicated	

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		that the Individual had a risk assessment of high for choking, aspiration, respiratory compromise, falls, fractures, and osteoporosis, among other conditions. The IRRF dated 2/4/2014 documented that the Individual was blind in the left eye secondary to glaucoma; however, the annual medical assessment did not document a diagnosis of glaucoma and for the medical plan it was stated "blindness in left eye: Follow up with ophthalmology". The only ophthalmology consult noted in the active clinical record was from 3/7/2014, that indicated the exam could not be completed because of behavioral challenges, and it would be necessary to complete the exam under anesthesia. Although the consult was signed off as reviewed by the Facility's medical provider, the medical provider did not document a note indicate a follow-up plan for the consultation report, but did write an order for the ophthalmology exam under anesthesia to be scheduled. This order was written on 3/11/2014; at the time of this compliance visit there was no evidence in the active clinical record to indicate the appointment date. Furthermore, there was no indication on the scheduling spreadsheet that the appointment was actually scheduled, and the scheduler reported that "it takes a while to get these things scheduled", and "we are trying to wait and get several things done, while (the Individual) is under anesthesia". The Monitoring Team is very concerned that there was no diagnosis of glaucoma documented on the medical plan, and that a specific plan to address blindness and possible glaucoma did not effectively document all necessary medical and other supports and services necessary to closely monitoring this individual for worsening vision. Given that the Individual is blind in one eye, the Monitoring Team determined that the Facility did not assertively address the Individual's need for more timely assessment. The annual medical assessment, dated 1/21/2014, documented diagnoses of compression fractures of L1, L2, and T11, and there was no medical plan developed to address necessary medical monitoring and other necessary supports and services. Furthermore, imaging studies from 1/25/2013 indicated that in addition to acute versus chronic compression fractures of L1, L2, and T11, there was also degenerative disc disease of the lower thoracic and upper lumbar spine. There was no evidence in the active clinical record that the individual was regularly assessed by the medical provider for possible worsening, or associated pain, and there was no consultation with spine specialists to assist with evaluating the issue. Given the Individual's significant fall risk, degenerative spine disease, that may progress to paralysis, and may manifest behaviors secondary to pain, the medical provider should have documented regular focused assessments for this condition. The annual medical assessment, dated 1/21/2014, indicated that the Individual had stage II renal insufficiency, and one kidney. There was no medical plan documenting the necessary medical follow-up for this condition; there was no documented etiology of the	

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		renal insufficiency on the annual assessment, and the IRRF did not indicate renal insufficiency as a high risk condition. In fact, the IRRF documented a high risk assessment for fluid imbalance because of the condition SIADH, and need for a fluid restriction, but there was no additional documentation on how potential dehydration from fluid restriction could impact renal insufficiency, and the need for very close monitoring. Summary: The Monitoring Team strongly suggests that the Facility ensure that medical providers develop comprehensive and clinically meaningful medical plans for all known and suspected medical conditions. For example, the medical plan should indicate all necessary medical monitoring and follow-up, as well as all necessary supports and services for each condition. The Facility continues to have an ineffective medical scheduling system,. Furthermore, there should be evidence that medical conditions have been effectively managed, and that the medical provider has evaluated their underlying etiology. <u>Follow-up to acute medical conditions</u> To assess the Facility's ability to manage acute medical conditions, the Monitoring Team requested the following documents for the first two reported acute medical conditions that occurred for each month during the reporting period. • 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 • All related consultation reports specific to the management of the acute medical condition The following is the Monitoring Team's summary of findings for acute care management for Individuals #65, #139, #131x2, #2, #63, #108, #85, #127, #36, and #11: • Ten out of 11 (91%) included a comprehensive and clinically appropriate initial assessment of the acute medical condition. Individual #131 was evaluated for two acute medical conditions on 11/21/2013; however, for one of the reported acute medical conditions, which was suspected bakers cysts, there was no documentation of bakers cysts being physically examined by the medical provider. • Of the 11 examples, seven examples (64%) demonstrated evidence indicating follow-up through full resolution of the acute medical condition by the medical provider. There were no IPNs by the medical provider indicating resolution of the acute medical condition for Individuals #63, #108, and #127, and there was no follow-up on the baker cysts diagnosed on Individual #131.	

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		• Eleven out of the 11 examples (100%) documented clinically appropriate consultative referrals and/or diagnostics. On-Site Observation of Acute Medical Management: During this compliance review, the Monitoring Team was made aware of two injuries. The following are some of the Monitoring Team's concerns: • Individual #5: The individual was reported to have fallen, and was found by nursing staff to be lying on the floor, face down. Nursing IPNs and the injury report did not document how the Individual was assisted back to chair, or bed, and the nursing IPN did not document a focused nursing assessment, other than vitals. This Individual is known to have significant musculoskeletal and neuromotor medical conditions, and a focused nursing assessment or medical assessment should have been documented to assess neurological signs, and musculoskeletal ability, and to specifically assess for fracture. • Individual #46: It was reported at the medical morning meeting on 05/21/2014 that the Individual sustained a broken tooth. An injury report was completed on 5/20/2014, stating that the Individual "walked into the nurses station stating a tooth had fallen out of his mouth while walking to nurses station". Details of the follow-up to this incident are found in Section Q. The Individual was seen by the medical provider on the same day. There was an extended delay before the individual saw the dentist for care. Medical assessment and care should have been more assertive, at least in response to monitoring and treatment for pain. Summary: Initial assessments by the medical provider were timely, clinically appropriate, and indicated the need for consultations and, or diagnostics, when clinically necessary; however, the two acute medical issues assessed while on site indicated ineffective initial triage of the acute medical conditions. There was only limited improvement in follow-up through full resolution of acute medical conditions. <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 experienced 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	

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		• 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 provided a written document stating that there were no instances of bowel obstruction or perforation. <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 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 Monitoring Team noted the following for the documents reviewed for the first five individuals on the list of all individuals with a diagnosis of cerebral palsy (Individuals #115, #85, #143, 19 and #61): • The diagnosis of CP was noted on the annual medical assessment in five out of five examples (100%). • There was a comprehensive plan documented on the annual medical assessment specific to the management of CP in zero out of five examples (0%). The plans	

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		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 five examples (0%). In no cases were deep tendon reflexes (DTRs) or range of motion reported to have been measured. • The Medical provider documented regular assessments for the potential manifestations of CP in zero out of five examples (0%). • Medical consultations were provided to address manifestations of CP, such as spasticity in one out of five examples (20%). • The ISP or other relevant documentation indicated that the IDT had a comprehensive understanding of CP, and how CP affects the Individual's life in zero out of five examples (0%). • The ISP and/or the IRRF documented all necessary supports and services for CP and spasticity in zero out of five examples (0%). • There was medication, such as Baclofen, Botox, or Baclofen pump for spasticity in zero out of five examples (0%). • The PT/OT assessment indicated specific measurements when assessing spasticity in zero out of five examples (0%). • There was evidence that specific PT/OT treatments were provided to help minimize progression of contractures in zero out of five examples (0%). 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; therefore, this condition must be assessed, and when clinically appropriate, necessary medical intervention must be provided. PT/OT must regularly assess actual range of motion measurements, in order to assess worsening contractures and spasticity. <u>Clinical management of fractures</u> The Facility reported six 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	

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		Facility systems review of fractures, and attempts to mitigate fractures • For all individual who had a long bone, or axial fracture, please provide the following (individuals #72, #65, and #84): 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 As with the last compliance report, the Facility did not provide a trend analysis, or develop specific plans to reduce fractures at the Facility. The only analysis provided for review was a more general Injury Trend Report for 2013 and 2014; however, this report did not specifically address fractures. As with the last compliance report, 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 Facility provided a document indicating that a total of six fractures had occurred during this reporting period; three of the six were either long bone, or axial fractures. The following is a summary of the Monitoring Team's findings, following its review of Individuals #72, #65, and #84 : • In three out of three examples (100%) the medical provider conducted a prompt initial triage for reported fractures. • In one out of three examples (33%) the medical provider regularly followed the Individual through full resolution of the fracture. • In two out of three examples (67%) the medical provider obtained necessary diagnostics and prompt consultation for the assessment and treatment of fracture. There were no diagnostics or consultation reports provided regarding the avulsion fracture for Individual #65. • In zero out of three cases (0%), the Medical provider documented a comprehensive assessment of all risk factors for fall and fracture. • In zero out of three cases (0%), PT/OT documented a comprehensive assessment of all risk factors for fall and fracture. Updated assessments by	

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		PT/OT following the fracture injury were not provided for review. • In two out of three cases (67%), the IRFF documented a comprehensive assessment of all risk factors for fall and fracture. The IRRF risk assessment was not updated following Individual #65's fracture. • In zero out of three 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. 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. 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>Medical Management of Malignancy:</u> The Monitoring Team requested a list of all individuals diagnosed with malignancy, along with the most recent annual medical summary, all consultations and associated diagnostics specific to the diagnosis of malignancy, most recent IRRF, and all ISP meeting minutes addressing the diagnosis of malignancy, for this reporting period. The Facility provided a list of one individual who had a diagnosis of malignancy of the stomach, in 2012 (Individual #150). The following are some of the Monitoring Team's comments and concerns regarding the management of this condition: • As part of the treatment for cancer of the stomach, the Individual underwent a Billroth II procedure. The potential complications of this procedure were not documented on the IRRF, ISP, or annual medical summary, and there was no evidence to indicate that such complications were subsequently reviewed by the IDT. Issues such as dumping syndrome, recurrent malignancy, malignancy developing in the remnant stump, and afferent loop syndrome should have been	

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		discussed by the IDT, supports developed, and specific monitoring and reporting parameters developed for such complications. • There were no documents outlining a discussion on recurrent H. pylori, and follow-up plan to ensure eradication of this organism. H. Pylori has potential significant ramifications, including GI related inflammation, ulceration, perforation, and potential malignancy. • The most recent issues noted from GI and oncology consultations were not reviewed by the IDT, including the recent finding of gastric wall thickening found on CT scan, and gastric metaplasia of the stomach found by EGD. • The annual medical plan did not have a plan developed for malignancy, or its related potential medical complications, other then "follow-up with oncologist". A well developed, and documented medical plan that clearly outlines the prognosis, necessary treatments and follow-up, necessary supports and services, and monitoring and reporting parameters is necessary for the IDT to gain a meaningful understanding of this serious medical condition. Summary: The Facility must ensure that the IDT is made well aware of all related medical issues, including prognosis, treatments, necessary supports and services, and monitoring and reporting parameters. In this particular case, specific monitoring for complications, as well early identification of signs for potential recurrence of cancer, could be life saving. <u>Clinical management of osteoporosis</u> To assess the Facility's ability to clinically assess and treat osteoporosis, the following 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 #79, #98, #19, #21, and #5): 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 provided a document indicating that 27 individuals were diagnosed with	

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		osteoporosis at the Facility, which was an increase of 17 individuals from the past compliance review. This finding indicates increased surveillance of low bone density by the medical provider. The Facility provided for review a document entitled Osteoporosis Guidelines for the PCP, which was undated and not numbered. The Guideline appeared clinically meaningful; however, the Monitoring Team would recommends the Facility to consider adding a statement regarding potential false negative results from DEXA scan, which could lead to under-diagnosis, and under-treatment of low bone density; abnormal positioning can result in false positive and false negative results, and such situations require a presumptive diagnosis based on clinical findings and medical history. The following are the Monitoring Team's findings from review of the documents related to the management of the assessment and treatment of osteoporosis for the sampled individuals: • Three out of five examples (60%) included annual medical summaries that indicated a clinically appropriate diagnosis for osteoporosis on the active problem list. The annual medical summary was not provided for Individual #21. The most recent annual medical summary for Individual #5 indicated an active problem list stating "osteoporosis"; however, under the subsection diagnostic procedures it was stated "borderline osteopenia", and review of the most recent DEXA report indicated a bone mineral density T-score of -2.8 for the lumbar spine which suggests osteoporosis. The medical plan stated that osteoporosis is "under treatment", however, upon reviewing the current medication list, the Individual was on 35 mg of alendronate each week, which is considered a preventive treatment dose, and the dosage recommended for treatment of osteoporosis is 70 mg each week. • 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. For example, the medical plan for osteoporosis for Individual #5 was "under treatment", and for Individual #19 "continue Prolia". • 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. It is essential that the medical provider attempts to determine the underlying etiology of the osteoporosis, and document the etiology, or suspected etiology. No such evidence was provided. • Five out of five examples (100%) included evidence that a clinically appropriate	

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		diagnostic was obtained to assess bone density and treatment efficacy, when clinically indicated. • Three out of five examples (60%) included evidence that a clinically appropriate pharmacological therapy was provided, as clinically necessary, to treat low bone density. Individual #5 was prescribed a preventative dosage of alendronate, with a vertebral T-score of -2.8, and there was no documentation to support the clinical rationale. Although the medical plan, and IRRF indicated that the Individual #19 was provided Prolia for the treatment of osteoporosis, the medication list on the most recent annual medical summary, and the most recent medication list did not list Prolia as a prescribed medication. In all cases reviewed, individuals were provided vitamin D and calcium. • Five out of five examples (100%) included osteoporosis as a risk factor on the most recent IRRF. Despite indicating a risk for osteoporosis, there were no examples that clearly defined important supports necessary for the management of this condition. For example, the IHCP should clearly describe a plan for close monitoring for pathological fractures, signs and symptoms of compression fractures, and important details regarding medication management for the treatment of osteoporosis. Summary: The Monitoring Team continues to recommend that medical plans developed for osteoporosis should include specific treatments, monitoring parameters, specific medical follow-up, and all necessary support and services that must be provided. In addition, the IRRF should more clearly define specific risks associated with osteoporosis, and the IHCP should address monitoring and reporting parameters for this condition, and associated medication management. <u>Clinical management of pneumonia</u> To assess the management of pneumonia, the Monitoring Team requested a list of all individuals who were diagnosed with pneumonia that occurred during the reporting period, and a list of all individuals with a known history of recurrent pneumonia. In addition, the Monitoring Team requested all reports and meeting minutes generated for the Facility's effort to minimize recurrent pneumonia at the Facility. The Facility provided documentation indicating that there were no cases of diagnosis of recurrent pneumonia, and only one case of pneumonia that occurred during the reporting period. Furthermore, the Facility indicated by written documentation that systems review of recurrent pneumonia was not applicable at this Facility. While on-site, the Monitoring Team attended the ISP meeting for Individual #126; during that meeting the medical provider indicated that the Individual had pneumonia, but because of the Facility's policy for the diagnosis for pneumonia the Individual was not officially	

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		diagnosed with pneumonia; review of the clinical record while on site corroborated a diagnosis of pneumonia, and possible history of recurrent pneumonia. The Facility's policy on pneumonia is exclusionary, and requires that several specific clinical criteria be identified, such as fever, elevated white blood cell count, and infiltrates on x-rays; although such requirements are appropriate for individuals in the general medical community, many individuals with developmental disabilities will not demonstrate such findings, until late in the clinical course, and therefore these diagnostic criteria must be considered but should not be used to exclude a diagnosis that is otherwise appropriate. The following is a review of the documents provided for the one Individual diagnosed with pneumonia, during the reporting period (Individual #33): • The Individual was diagnosed with "healthcare associated pneumonia" on 11/24/2013. Review of documents provided documented there were follow-up consultations for possible pneumonia that occurred during March 2014, and there were no associated medical provider IPNs documenting a final determination of pneumonia. • The only medical plan listed on the most recent annual medical summary, dated 4/4/2014, for the diagnosis of "mild dysphagia" was "on modified diet with thin liquids". The medical plan should include all necessary medical treatments, medical follow-up, monitoring and reporting parameters for this medical condition, and necessary supports. • The most recent PT/OT assessment, dated 3/10/2014, indicated that a modified barium swallow test demonstrated "mild oropharyngeal disorder"; copies of the most recent swallowing study, and esophagram were not provided for review. • The Monitoring Team was provided PNMT minutes dated 12/03/2013, that indicated the Individual was diagnosed with pneumonia and hospitalized from 11/25/2013 through 11/28/2013, and the post hospital ISPA had "not been held yet and QIDP mentioned this morning that it will probably be held tomorrow (12/4/2013)". There was no evidence provided to indicate that the post hospital ISPA meeting had occurred. Summary: The Facility reports a very low rate of pneumonia; however, the Monitoring Team is aware of one incidence of pneumonia that was under-diagnosed because of the Facility's policy on diagnosing pneumonia. Furthermore, the Facility reported that it does not have a process to evaluate systems issues secondary to pneumonia. The Monitoring Team strongly recommends that the Facility re-evaluate its process of diagnosis and reporting pneumonia. The Facility must ensure that all cases of pneumonia are carefully reviewed by the IDT.	

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		Conclusion: The Monitoring Team noted significant improvement, since the last compliance visit, with regard to updating medical diagnosis, and better ensuring that acute and chronic medical conditions are identified, and treated; there is, however, further progress to be made in this area. A continued significant area of deficiency was noted in incorporating medical issues and plans to address those into the interdisciplinary team process. Medical diagnoses, necessary treatments, medical follow-up, important monitoring and reporting parameters, and all necessary supports and services provided for each medical condition were not addressed on the annual medical summary, ISP, or IRRF, and not all were addressed at the ISP meeting. Although, in general, acute medical issues were initially triaged by the medical provider, there was no evidence of consistent follow-up by the medical provider through full resolution of the acute condition. Furthermore, there was no evidence provided to demonstrate the medical provider's regular review of the underlying causative factors of medical conditions. The Monitoring Team would like to emphasize the importance of comprehensive, interdisciplinary care for all medical conditions, with significant emphasis on the Facilities management of neuromotor and musculoskeletal conditions.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	To assess the Facility's development and implementation of a review system that consists of non-facility physician case review to facilitate the quality of medical care and clinical performance, the Monitoring Team reviewed the external medical audit reports and associated policies and procedures for the medical audit process (DADS Policy: Medical Provider External/Internal Audits, revised July 6, 2012 – no number). The 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, round 8, that was conducted on December 13, 2013. The external audit was conducted by a physician external to the Facility. The Facility provided the Analysis of Internal/External Medical Provider Audit: Round 8. The one full-time medical provider was assessed by the medical audit review. 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 the one practicing medical provider indicated the following (note that all information provided regarding the analysis was devoid of identifying information): • A total of 12 records were reviewed.	Noncompliance

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		• The medical provider achieved a score of 89% for non-essential elements, which was considered as a "passing" score 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 two medical management reviews
		  o Constipation had a cumulative score of 75%.
		  o Seizures had a cumulative score of 65%.
		
		Review of the medical management questions assessed for constipation and seizure 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.
		
		The Monitoring Team was not provided with a summary of the action plans necessary to address the deficiencies identified from the external audits for round 8.
		
		The Monitoring Team was provided a document stating that the clinical director did not discuss the findings of round 8, and did not include the findings within the context of peer review. With this statement and no summary of actions plans to address deficiencies, it appears no action had been taken based on the findings of the external audits. This is a crucial finding. The purpose of the audits is to improve care, and the Facility must use the findings to plan corrective actions and to improve performance.
		
		The Monitoring Team discussed the process for the medical internal and external medical audits with the Facility's clinical director, who informed the Monitoring Team that no additional enhancements had been developed in the area of assessing medical provider's performance.
		
		Summary:
		The current medical provider audit process did not adequately assess clinical performance outcomes, and mostly assessed if the medical provider follows Facility procedures. The clinical director did not use the results of the audit process within the context of a peer review process, by reviewing the results with the medical provider who was assessed. Also, there was no evidence provided to indicate that action plans were completed, or if action were assessed for efficacy. Furthermore, the audit process did not include a substantial component to assess if the medical provider was practicing at the most current acceptable professional standard treatment for the medical condition	

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		assessed. <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. In addition, the Facility reported no deaths occurring during the reporting period; therefore the Monitoring Team did not observe the mortality review process or assess any documentation of mortality review. Conclusion: The current medical provider audit process did not utilize findings from the review within the context of a peer review process, by reviewing the results directly with the medical provider. There was no evidence provided to indicate that action plans were completed, or to assess action plans for efficacy. Furthermore, the audit process did 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, if appropriate medical supports and services are efficacious or, if not, that the medical provider reconvenes with the IDT to further develop strategies that will enhance clinical outcome.. 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; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	To assess the Facility's ability to develop and implement a process for medical quality assurance, that it collects clinical data, and conducts trends analysis of clinical outcomes, the Monitoring Team discussed the Facility's medical quality assurance process with the clinical director, and reviewed the most recent internal medical audits. <u>Internal Medical Audits</u> The most recent internal medical audit, round 8, occurred on 12/20/2013. A Facility physician who was assigned to the Mental Health component of the Facility conducted this audit. One medical provider was assessed by the internal medical audit process: • The medical provider achieved a Facility determined passing score of 80% or 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. • The Monitoring Team was not provided with a summary of the action plans developed for the external audits for round 8, that included the number of action	Noncompliance

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		plans developed, and date the action plans were completed. The Monitoring Team noted that only two medical management elements were assessed (constipation, and seizures). 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: As per Section L.2, of this report, the Monitoring Team has concern over the internal medical audit process's not utilizing findings from the review within the context of a peer review process, by reviewing the results directly with the medical provider. There was no evidence provided to indicate that action plans were completed, or to assess action plans for efficacy. Furthermore, the audit process did not adequately 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 accepted professional standards of care. The Parties shall jointly	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 provide a Standard Operating Procedure ICF-IID 400 14; Medical Care, dated November 2004, and revised July 2013. No additional revisions for this policy were developed during the reporting period. This procedure was comprehensive and	Noncompliance

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	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.	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. RGSC Standard Operating Procedure, Minimum Common Elements of Care, ICF-IID 400 19, 01/21/2014 delineated essential elements of health care practice at the Facility, including medical, and psychiatric care. A positive finding is that the procedure calls for the development and implementation of clinical pathways for care. Following review of the procedure, the Monitoring Team determined that the Facility did not yet substantially implement the procedure at the Facility. Conclusion: The Facility continues to be noncompliant with Section L.4 because it has not substantially implemented its standard operating procedure for health care, or developed and implemented additional essential policies and procedures to ensure that medical care is consistent with generally accepted professional standards of care. The Facility should have operational procedures that delineate standards and expectations for the provision of medical care. The Monitoring Team compliments the Facility for the call for the development and implementation of clinical pathways for care established in Standard Operating Procedure, Minimum Common Elements of Care and looks forward to assessing progress on implementation of this policy at the next visit.	

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: 5/7/14 2. RGSC Section M Action Plans, Updated: 5/7/14 3. RGSC Section M Presentation Book 4. RGSC SOP IFC-IID 100 16, Morning Medical Report, Revised: March 2014 5. RGSC SOP ICF-IID-700 14, The Use of Restraint, June 2012 6. RGSC Environment of Care Manual: Standard Operating Procedure (SOP) EC 300-07A, Safety/Risk Management/Infection Control Committee Policies and By Laws, Review/Revised: December 2013 7. RGSC Environment of Care Manual: Surveillance, Prevention, and Control of Infection Manual Table of Content 8. RGSC SOP NR200-400-12 Medication Variance Policy, Reviewed: May 2013 9. RGSC SOP NR 400-08, Medication Administration Guidelines, Reviewed: May 2013 10. RGSC Nursing Organizational Chart, 4/17/14 11. RGSC Daily Morning Medical Reports for 5/19/14 through 5/23/14 12. RGSC 2013-2014 Nurse Education and Training Database 13. RGSC Jobs Skill Orientation Check List and Competency Evaluation Triennial Facility Process and Priority Review, Revised: November 2011 14. RGSC Nursing Staffing Patterns by Shift 15. RGSC Nursing Staffing Schedule, January 2014 and February 2014 16. RGSC Nursing Employee Positions List 17. RGSC List of Registered Nurse (RN) Case Managers' Caseload, April 2014 18. RGSC Roles and Responsibilities for Campus Nurse-RN III, 19. RGSC Schedule of Meetings Requiring Nursing Participation During the Week of the Compliance Review 20. RGSC Acute Care Plan (ACP) Process Outline/Summary 21. RGSC Monthly ACP Trending Report by Home, October 2013 through April 2014 22. RGSC Blank Nursing Referral Form 23. RGSC List of Individuals who Refused Appointments, 3/16/14 24. RGSC Blank Nursing Events Daily Log 25. RGSC ICF-IID Nursing Meeting Minutes, 12/2/13, 1/16/14, 2/6/14, and 3/20/14 26. RGSC Safety/Risk Management/Infection Control Committee Meeting Minutes, 11/21/13, 12/16/13, 2/3/14, and 3/20/14 27. RGSC RN Case Managers' Meeting Minutes, 12/10/13, 12/16/13, 12/31/13, 1/28/14, 2/4/14, 2/11/14, 3/18/14, and 4/1/14 28. RGSC Physical Nutritional Management Team/Skin Integrity Committee Meeting Minutes for the past two months 29. RGSC Departmental Performance Measures, Infection Prevention and Control/Employee Health, Q2FY14

	30. RGSC Antibiotic Susceptibility of Common Organisms, January 2013 through December 2013 31. RGSC February and March 2014 Infection Data 32. RGSC Antibiotic Therapy Monitoring Data for Q1FY14 33. RGSC Infection Control Prevention and Practices Training Guidelines 34. RGSC Infection Control Prevention and Practices Workbook, 11/10/11 35. RGSC Percentage of staff vaccinated for Hepatitis B 36. RGSC Percentage of staff current with flu vaccinations 37. RGSC Percentages of staff current with Tuberculosis (TB) Skin Testing or other follow-up for those who have converted skin test 38. RGSC Percentage of individuals current with TB skin testing 39. RGSC Performance Improvement Report, FY 2014 IFC-IID Nursing, El Paisano and La Paloma 40. RGSC Physical Nutritional and Management Team Monitoring Data for Nursing for Past Six Months 41. RGSC Trigger Sheet Process 42. RGSC Emergency Drill Checklists, November 2013 through March 2014 43. RGSC Medical Equipment Maintenance and Location List 44. RGSC List of Staff Responsible for Conducting Mock Medical Emergency Drills 45. RGSC Competency and Development Course Due/Delinquent List for Cardiopulmonary Resuscitation (CPR) Basic, Printed 4/30/14 46. RGSC Competency and Development Course Due/Delinquent List for Basic Life Support (BLS) for Health Care Providers, Printed 4/30/14 47. RGSC Competency and Development Course Due/Delinquent List for Infection Control Refresher Training, Printed 4/15/14 48. RGSC Incident Management Review Team Meeting Minutes for the past six months 49. RGSC Completed Monthly Medication Administration Observations Audit Sheets, November 2013 through April 2014 50. RGSC Monthly Medication Administration Observation Audit Summaries, November 2013 through March 2014 51. RGSC Medication Investigation Summary Reports, March 2013 through March 2014 52. RGSC Medication Management Workgroup Meeting Minutes, 7/23/13, 10/28/13, 12/17/13, 2/25/14, and 4/25/14 53. RGSC Pharmacy and Therapeutics Committee (P&TC) Sub-Committee Meeting Minutes, 10/17/13 and 1/8/14 54. RGSC Facility's At Risk Individuals Data, to date 55. RGSC List of Key Indicators 56. RGSC Monthly Section M Key Indicators Monitoring Data, October 2013 through March 2014 57. RGSC Monthly Nursing SA-PIC Audit Data, November 2013 through February 2014 58. RGSC Copies of Blank Section M – Nursing Monitoring Tools and Instructions 59. RGSC Nursing Assessment Schedules for RN Case Managers 60. Sample Record Review of Most Recent Comprehensive Nursing Reviews/Quarterly Nursing Record Reviews/Quarterly Physical Assessments for Individuals #62, #38, #75, #103, #115, #101, #29, #19, #108, and #126 61. Sample Review of Nursing Discharge Summaries and Community Living Discharge Planning Packets for

	Individuals #132 and #149 62. Sample Record Review of Most Recent/Active Reported Infections for Individuals #19, #108, #36, and #38 63. Sample Record Review of Recent Hospitalizations for Individuals #62 and #11 64. Sample Record Review of Recent Seizure Activity for Individuals #74, #98, #60, and #86 **People Interviewed:** 1. Maia Baker, RN, Chief Nurse Executive (CNE) 2. Belinda Portales, RN, Nursing Operations Officer (NOO) 3. Hilaree Mariboa, RN, Unit Nurse Manager 4. Angela Villarreal, RN, Nurse Educator 5. Jamie Rodriguez, RN, RN Case Manager 6. RN Case Managers 7. Numerous Floor Nurses and Direct Support Professionals 8. Jessica Galindo-Juarez, RN, Infection Control Preventionist **Meeting Attended/Observations:** 1. Review of Section M Presentation Book with Chief Nurse Executive, Nursing Operations Officer, Unit Nurse Manager, and Nurse Educator, 5/19/14 2. Medication Administration and Enteral Nutrition Observations, 5/20/14 and 5/22/14 3. Morning Medical Report, 5/20/14, 5/21/14, and 5/22/14 4. Physical Nutritional and Management Team (PNMT)/Skin Integrity Committee Meeting, 5/20/14 5. Meeting with Facility Administrative/Clinical Staff Regarding Individual #126, 5/21/14 6. Annual ISP Meeting for Individual #140, 5/22/14 7. 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 Care Assessment and Protocol Audit Tools, Infection Control data, Mock Medical Drill Audits, and Medication Administration Observations 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 did not include 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 did not have 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. However, not all of the monitoring tools developed were used consistently to evaluate the respective issues for which they were developed. ▪ 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: a. 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. b. Did not measure the quality of items. c. Distinguished data collected by the QA Department versus the Nursing Department. The Facility also provided an Action Plan to move toward compliance. The action planned 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 Plan 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: 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. Since the last compliance review, there was no appreciable improvement found in any of the Provisions. Therefore, none of the Provisions were found in substantial compliance. However, the recently hired Chief Nurse Executive was in the process of restructuring and reorganizing the Nursing Department. It is expected with these changes and with the full support of the Facility's Administration, if given the authority, the Chief Nurse Executive will be able to improve nursing services and move the Nursing Department forward toward meeting substantial compliance with these Provisions. **Provision M.1**: The Nursing Department was fully staffed a with newly hired Chief Nurse Executive and Nursing Operations Officer, along with Unit Nurse Manager Nurse Educator and four RN Case Managers; with these staff, the Nursing Department should have adequate administrative and management staff. In addition, 14 nursing positions were allocated and positions were being filled. None of the requirements contained in this Provision showed appreciable improvement, as reported below. However, with the newly hired Chief Nurse Executive's plans for restructuring and organizing the Nursing Department with increased accountability of the nursing staff, it is expected that improvements will be made to help move all of the requirements in this Provision toward substantial compliance. The Monitoring Team did not find substantial compliance with this Provision. **Provision M.2:** It was apparent through review of the Self-Assessment, interviews with Nursing

	Administration, and review of documents that concerted efforts had been made to improve the timeliness and quality and content of the Annual/Quarterly Nursing Assessments. At this compliance review there was no appreciable improvement found with this Provision. The Monitoring Team did not find substantial compliance with this Provision. **Provision M.3**: It was apparent through review of the Self-Assessment, interviews with Nursing Administration, and review of documents that concerted efforts had been made to improve the implementation of Acute Care Plans. However, there was minimal improvement in the development and implementation of Acute Care Plans. Nursing administration was not aware of revised DADS SSLC Care Plan Development Guidelines. During the compliance review the Chief Nurse Executive gained access to the State Office Shared drive for the revised guidelines. The guidelines will be implemented and the nursing staff trained. This should further improve the quality of the Acute Care Plans. The development and implementation of the Integrated Risk Rating Form and Integrated Health Care Processes were continuing to evolve, as reported in Provision M.5. The Monitoring Team did not find substantial compliance with this Provision. **Provision M.4:** The Nurse Educator continued to maintain a centralized Nurse Education and Training Database. The Nurse Educator continued to use the state competency-based Nursing Education Hand Book for New Nurse Orientation and annual competencies refresher training. Annual competencies refresher training is to begin in May 2014. The plan was to conduct training on two competencies, including nursing protocol, each month during the monthly nursing meetings. The Nursing Department should ensure sufficient time is allotted to adequately conduct the monthly training/refresher/competencies as part of their monthly nursing meetings. The core competency-based annual refresher training should not only include didactic instructions but also include a practicum to demonstrate competency and perform the required skills. The nursing staff was observed carrying with them a set of Protocol Cards, but record review found lack of adherence to following relevant Nursing Protocols. The Monitoring Team did not find substantial compliance with this Provision. **Provision M.5:** As was found in past reviews, the IRRF and IHCP processes were evolving. As more training is provided and IDT members gain experience 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:** The Facility continued medication cart exchanges in the Pharmacy. Each nurse was paired with a pharmacy technician to conduct the cart exchange. This improved the efficiency and accuracy of the exchange, enhanced the ability to reconcile medications, and reduced distractions. The nurses observed continued to administer medications and enteral nourishment according to generally accepted standards for safe administration. The manner in which the medication variance data were represented made it difficult to interpret. Medication variance data should be analyzed monthly, quarterly, and longitudinally.

	The Medication Management Workgroup Committee and Pharmacy and Therapeutics Committee need to conduct a more in-depth review of medication variances to ensure that local as well as systemic corrective actions are taken to mitigate medication variances and to evaluate the effectiveness of the corrective actions taken. The Facility needs to ensure that medication variance data are clearly separated from the Mental Health Hospital and Outpatient Clinic data. The medication variance data reported should ensure medication variances are reported for each discipline, respectively, i.e., nursing pharmacy, and medical staff. The Facility Self-Assessment stated they were not in substantial compliance with this Provision and the Monitoring Team concurs.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	The Monitoring Team verified 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, and Nurse Educator. 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 Section M included a number of requirements that addresses various areas of compliance. These requirements include: Staffing, quality assurance efforts, assessment and documentation of individuals with acute changes in status, availability of pertinent medical records, infection control, and the emergency response system. Additional information regarding the nursing assessment, development, and implementation of health care plans are found below in Provisions M.1, M.3, and M.5 of the report. Information and recommendations regarding nursing documentation on restraint usage is included above in Provision C.5 of this report. <u>Staffing</u> At the time of the compliance review the Facility census was 66. It was positive to find that a new and experienced Chief Nurse Executive was hired in March 2014. Under her leadership, with the support of the Facility's administrative staff, she should be able to bring about improved organization and structure to the Nursing Department. In addition, a new Nurse Operations Nurse was hired in May 2014, who was the former Quality Assurance Nurse. The Nursing Department continued to have the same Unit Nurse Manager and Nurse Educator as was found at the last compliance review. With the four key leadership staff positions filled there is the potential to build a competent nursing service. It was evident thorough interviews and review of documents that the leadership 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	Noncompliance

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		there is retention of the recently hired staff. The Infection Control Preventionist continued to manage 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. A new RN Case Manager was hired in February 2014. With this new RN Case Manager, the Nursing Department had four RN Case Managers. The four RN Case Managers should be sufficient to case manage 66 individuals' health care needs, based on average caseload ratio of approximately 1:16 individuals. Individuals who resided in La Paloma were more medically fragile, while individuals who resided in El Paisano had more behavioral issues. Since the last compliance review, the Nursing Department was allocated 14 new full time nursing positions, of which seven were RNs and seven were LVNs. Four of the RN positions were filled, with three vacancies. Six of the LVN positions were filled, with one vacancy. During the last compliance review, the Nursing Department employed 27 agency nurses. Because of the additional nursing positions, currently only six full time and five part time agency nurses were employed. The Nursing Department planned to re-evaluate the use of agency nurses once all of the new nursing positions are filled and fully trained and determined competent. The nursing staffing raw data provided, November 2013 through March 2014, did not show an analysis by unit, month, and shift. The data was not analyzed to determine whether any of the shifts had fallen below the established minimum staffing ratios. The Nursing Department continued to collect monthly data for hours of overtime used by the full time nursing staff and the hours used by agency nurses. As of February 2014, the Facility reported a turnover rate of 4.65% for LVNs and 1.37% for RNs. <u>Quality Enhancement Efforts:</u> The Monitoring Team conducted a review of Quality Enhancement Activities and found: 1. As was found at the last compliance review, the Nursing Department did not have a formalized written quality assurance audit process. Nursing Administration stated that the RN Case Managers conducted the monthly nursing audits on the Annual/Quarterly Nursing Assessments Audit Tool and Protocol Audit Tools for Respiratory Distress/Aspiration and Constipation. Each RN Case Manager monthly conducted audits on one of the above audit tools on records selected from partner's caseload. Only two of the 23 Protocol Audit Tools were audited. There was no baseline data collected to the remaining 21 Protocol Audit Tools, particularly for frequently occurring health conditions that required the implementation of the respective protocols. Once the audits were completed by the RN Case Managers they were sent directly to the Quality Assurance Department without being reviewed first	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
by Nursing Administration. The results of the audits were not known to Nursing Administration until they were presented on Section M at the SA-PIC (the Facility's quality assurance committee) meetings. Therefore, there was no opportunity for Nursing Administration to ensure that the audits were completed timely or reviewed to identify deficiencies that may have needed immediate local and/or systemic corrective actions. There was no inter-rater reliability check process in place.
2. The Nursing Department's established threshold for compliance was a score of 90%. 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. However, there was no monitoring data provided to review from the SA-PIC meetings. As was found at the last compliance review, the Nursing Department's efforts for completing quality assessments activities showed no appreciable improvement. The need to enhance the Nursing Department's quality assurance process was discussed with Nursing Administration, who agreed that the process needed to be improved.
3. The Facility's reported Self-Assessment Annual and Quarterly Nursing Assessment audit data for timely completion November 2013 through March 2014 is shown in the chart below:
<table>
<tr><th>Key Indicators</th><th>November 2013</th><th>December 2013</th><th>January 2014</th><th>February 2014</th><th>March 2014</th></tr>
<tr><td>Annual Nursing Assessments</td><td>14%</td><td>0%</td><td>86%</td><td>100%</td><td>100%</td></tr>
<tr><td>Quarterly Nursing Assessments</td><td>NA</td><td>NA</td><td>81%</td><td>71%</td><td>71%</td></tr>
</table>
The explanation provided in the Facility's Self-Assessment for the low scores was due to the resignation of a Case Manager in November and to another RN Case Manager being on personal leave in December 2013. Consequently the interim CNE restructured the supervision to help the RN Case Managers reorganize the team's priorities. In January 2014, as a result of the enhanced supervision the timely of completion of the Annual Nursing Assessment improved. There were no audit data provided for audits conducted on the Protocol Audit Tools for Aspiration and Constipation.
4. According to the Facility's Self-Assessment the Nursing Department monthly audited Physician Orders using an updated 24 Hour Chart Check Audit Tools. The chart below reports results of the audits conducted November 2013 through March 2014:
<table>
<tr><th>Key Indicators</th><th>November 2013</th><th>December 2013</th><th>January 2014</th><th>February 2014</th><th>March 2014</th></tr>
<tr><td>Physician Orders correctly</td><td>92%</td><td>88%</td><td>99%</td><td>98%</td><td>93%</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance

transcribed and/or carried out						

Corrective Action Plan: The Unit Nurse Manager will develop a schedule of 10 individuals' records per night for the nurse to perform the 24 Hour Chart Checks, utilizing the new RN III as the lead auditor. This schedule will rotate and cover the census twice a week. Nurses will use the updated audit form to ensure the accuracy of orders.

5. 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.

<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 Medical Morning Report meetings on 5/20/14, 5/21/14, and 5/23/14. The Facility had continued to conduct and to expand the integrated participation of staff attending the meetings, which included representatives from the various departments including: Medical Providers, Nursing Services, Infection Control Preventionist, Habilitation Services, Behavioral Services, Psychiatry, Dietary Services, Residential Services, Qualified Intellectual Disability Professionals, and Ombudsman. The Clinic Nurse presented the Morning Medical Reports. The Medical Clinic Clerk served as the scribe to record the minutes of the meetings. The reports were driven by a specific agenda to review all changes in health care status of individuals over the past 24 hours as well as those occurring over the weekends and holidays. The purpose of the meetings was to triage and discuss urgent clinical issues to ensure continuity of care and to enhance clinical management of individuals. Issues discussed included, but were not limited to: review/revision to previous minutes; unfinished business; medical on call reports; clinic reports; psychiatric/behavioral issued; pending medical consultations; missed/refused appointments; wound care; infectious disease issues; and significant medical conditions.

  The Monitoring Team's observations of Morning Medical Reports and review of the Morning Medical Report minutes for the week of the compliance review showed some continued improvement over time in the integrated participation by representative disciplines. However, the Clinic Nurse presenting the reports read the information and rarely paused sufficiently to engage the participants in meaningful interdisciplinary interactions, nor was there sufficient discussion on clinical issues that should require follow-up actions. Neither were there follow-up

#	Provision	Assessment of Status	Compliance
		reports provided on previously discussed issues that included actions for follow-up. Nursing Administration should ensure that clinical issues requiring nursing services are followed-up, particularly by the RN Case Managers. Nursing Administration agreed that clinical issues from the Morning Medical Reports that required nursing services attention should be followed-up. For example: On 5/21/14, during the Morning Medical Report a RN Case Manager reported that Individual #5, who was known to have significant medical issues had fallen on the floor. There was no discussion to determine if a nursing/medical assessment had been completed to help rule out possible injury. Given Individual #5's complex medical issues, this included high risk for falls and fractures and bruising/blood clotting problems. A focused assessment should have been completed to rule out possible fracture and/or bruising/bleeding resulting from the fall. The Monitoring Team, along with Nursing Administration, reviewed Individual #5's Integrated Progress Note for 5/21/14 at 12:17 a.m. The documentation showed that a focused assessment was not completed according to the Fall/Suspected Fall Protocol, although the plan stated that the protocol was initiated and direct support staff were instructed to report any changes of level of consciousness, vomiting, or distress. There was no further documentation regarding assessment of the fall. It is imperative when individuals fall that nursing assessments continue to be completed to ensure that there are no fractures and/or bruising that may not show up immediately. • 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' (the Facility's process for corrective actions) for missed appointments were provided for review at the Morning Medical Report meetings. The reasons for the failure to keep the appointments were documented and a CATW2 was completed for the missed appointments when indicated. The Monitoring Team completed a comprehensive record for nine individuals with high/medium risk conditions selected from both units, Individuals #62, #38, #75, #103, #115, #29, #19, #108, and #126. A review of these individuals' records for Assessment and Documentation of Individuals with Acute Changes in Status found no appreciable improvement from the last compliance review in the documentation found in the Integrated Progress Notes. General findings included: • Lack of complete and appropriate nursing assessments of 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.	

#	Provision	Assessment of Status	Compliance
		• Lack of analysis of contributing problematic issues affecting acute changes in status. • Inconsistent initiation of Acute Care Plans and relevant nursing protocols for individuals who experience acute changes in status. • Significant gaps in documentation when the Integrated Progress stated, "will continue to monitor." The nurses consistently failed to state what would be monitored and the frequency of the monitoring. • Lack of follow-up of issues noted in previous nurses' progress notes. • Lack of documentation through to resolution for acute changes in status. • Lack of specific description of physical appearance, size, and location of skin rashes, injuries and/or bruises. • Lack of consistent documentation of the administration and follow-up response to per needed treatments (PRNs). • Lack of mental status assessments documented during status changes and/or specific descriptions when individuals were engaging in maladaptive behaviors. • Lack of documentation that there was communication with other relevant disciplines when there were acute changes in individuals' health or behavior status. Nursing Administration should enhance monitoring of assessment and documentation of acute changes in status to ensure the required assessments and documentation of acute changes in health status are consistently completed. <u>Availability of Pertinent Medical Records</u> 6. Four Quarterly Physical Assessments requested for offsite review were not provided. Therefore, it was presumed that they were not completed. 7. A random review of individuals' "Me Book" included relevant Acute Care Plans. However, all the plans reviewed had been resolved. The Unit Nurse Manager stated that the nursing staff were not allowed to remove the resolved plans from the "Me Books". Nursing Administration should inform the Recordkeeping staff when Acute Care Plans are resolved so that they can remove them from the "Me Books". Otherwise, the Direct Support Professional may continue their instructions. <u>Hospital Liaison Nurse Activities:</u> The RN Case Managers were responsible for performing Hospital Liaison Nurse Activities. The Monitoring Team requested sample records for individuals recently or currently hospitalized from each RN Case Manager. Documents requested included related Integrated Progress Notes leading up to the necessity for the hospitalization through to resolution, Physician's Orders, and all other documents required by the Urgent Care/ER/Hospitalization/Transfer Policy/Protocol. One of the four RN Case Managers did not have individuals who were recently or currently hospitalized or sent to the emergency room. Records were reviewed for Individuals #62 and #11. Findings	

#	Provision	Assessment of Status	Compliance
		included. • Zero of two (0%) individuals' records reviewed showed documentation as required in: DADS Policy 010.3 Nursing Services, 6/17/13, DADS Nursing Protocol: Hospitalization, Transfers and Discharges, June 2011, and Nursing Protocol: Emergency/Hospital Transfers Protocol Card. • Zero of two (0%) individuals' Acute Care Plans were individualized sufficiently to meet the individuals post hospitalization health care needs. • Zero of two (0%) individuals' Integrated Progress Notes showed documentation that the Acute Care Plans were followed as stated in the plans and carried out through to resolution. As was found in previous compliance reviews, there was lack of consistent adherence to emergency room, hospitalization, and transfers nursing policy and protocols. In order to meet compliance with this requirement, Nursing Administration should consider re-training the RN Case Managers and floor nurses on DADS Policy 010.3 Nursing Services, 6/17/13, DADS Nursing Protocol: Hospitalization, Transfers and Discharges, June 2011, and Nursing Protocol: Emergency/Hospital Transfers Protocol Card. <u>Infection Control Activities</u> 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 following positive Infection Control practices: • The percentage of individuals' current with Influenza Vaccinations was reported as 97%. • The percentage of individuals' current with Tuberculosis (TB) Skin Testing was reported as 97%. There were no individuals' reported that had converted TB Skin Tests. • The percentage of employees current with Influenza Vaccinations was reported as 100%. • The percentage of employees' current with Tuberculosis (TB) Skin Testing was reported as 100% and/or annual questionnaires. • The percentage of employees vaccinated with Hepatitis B was reported as 100% having started the Hepatitis B vaccination series, with 88% having completed the entire series and 12% in the process of completing the series. • CTD Due/Delinquent List for infection Control annual refresher training showed one employee was delinquent. • Handwashing Observations continued to be completed and reported monthly. All areas were reported as meeting 100% compliance for the First and Second Quarter of FY14. • Environmental Surveillance Observation continued to be completed and reported	

#	Provision	Assessment of Status	Compliance

monthly campus-wide. Areas identified with deficiencies were reported and corrective action plans implemented and carried out. Overall 100% compliance was reported for First and Second Quarter of FY14.

- The Infection Control Preventionist continued monthly monitoring of infections and Antibiotic Therapy Monitoring. Reports for September 2013 through February 2014 showed no significant improvement from previous compliance reviews as reported in the chart below:

Month/Year	Home	Notification of and documentation in the Integrated Progress Notes	Daily documentation of evaluation of problem/antibiotic therapy until resolution	Completion of Acute Care Plans
September 2013	El Paisano	0%	25%	0%
	La Paloma	0%	0%	0%
October 2013	El Paisano	20%	20%	20%
	La Paloma	0%	25%	25%
November 2013	El Paisano	0%	33%	0%
	La Paloma	66%	0%	33%
December 2013	El Paisano	17%	0%	33%
	La Paloma	0%	0%	0%
January 2014	El Paisano	0%	20%	20%
	La Paloma	0%	0%	50%
Overall Compliance		10.3%	12.3%	18.1%

As was found at the last compliance review, there was documentation that the Infection Control Preventionist reported the above data to nursing administration, pointing out the deficiencies and recommendations for corrective action. There was no documentation provided to indicate that corrective action plans were developed

#	Provision	Assessment of Status	Compliance
		and implemented to improve reporting infections and antibiotic therapy use, documentation in the Integrated Progress Notes regarding the evaluation of the infections, therapeutic response to antibiotic therapy through to resolution, and 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 ACPs for individuals who had infections. • Antibiograms for the susceptibility of antibiotics to common organisms continued to be developed and presented to the medical staff to use when prescribing antibiotic therapy. • Immunizations continued to be entered into the AVATAR Database but were not totally updated at the time of the review. The Infection Control Preventionist stated they continued to work with Data Analysis to figure out how to enter various antibody titers into the system for individuals who had immunity to various diseases that would not require vaccinations. The Safety/Risk Management/Infection Control Committee Minutes were provided and reviewed for 11/21/13, 12/16/13, 2/13/14, and 3/20/14. The Committee was jointly conducted with ICF-IID, Mental Health Hospital, and Out Patient Clinic. There were no Committee Meeting Minutes provided for April 2014. A review of the minutes found: • Committee Meetings were conducted monthly as scheduled. • Core Members consistently attended the Committee Meetings with rare exceptions. • Data from the Antibiotic Monitoring Reports were presented and discussed at the Committee Meetings along with the corrective actions taken to improve reporting. • Infections by type, rate, and unit were present and discussed by the number of antimicrobials prescribed and whether they were Healthcare-associated Infections (HAIs). The minutes stated to see the attached actual infections by type. However, the attachments were not included with the minutes for review. Therefore, it was not possible to determine the infections by type and incidences. • Environmental Surveillance and Handwashing Reports were presented and discussed, along with corrective actions taken, at the Committee Meetings. On 5/19/14, the Monitoring Team met with the CNE, NOO, and Infection Control Preventionist and discussed the need to enhance communication/collaboration between the Nursing Department and Infection Control Preventionist regarding the "real time" report of infections diagnosed and treated with antibiotics. The Nursing Department did not have a formalized process for "real time" reporting this information to the Infection Control Preventionist. Typically, the nursing staff called or e-mailed this information to the Infection Control Preventionist but there was no tracking system to ensure this was consistently done. The Infection Control Preventionist conducted monthly Antibiotic Monitoring audits, as reported above, which showed poor compliance with the criteria	

#	Provision	Assessment of Status	Compliance
		audited. The CNE and Infection Control Preventionist agreed there needed to be an enhanced process for ensuring "real time" reporting of infections and use of antibiotics. In addition, the Nursing Administration and the Infection Control Preventionist need to ensure that individualized Acute Care Plans for each specific infection are promptly initiated with all relevant nursing protocols incorporated into the plans, plans are followed as stated, and carried out through to resolution. The Integrated Progress Notes (IPNs) should include documentation that the Acute Care Plans were initiated and Direct Support Professionals were trained on all three shifts as well as nursing care provided to verify that the plans were carried out through to resolution. There should be a resolution note that describes the response to the plans and whether the infections were resolved. After the meeting, the Monitoring Team, along with the CNE, NOO, and Infection Control Preventionist, toured both units' bathrooms, medication rooms, and nursing treatment rooms in both units. Numerous environmental deficiencies were found in the bathrooms with dirty clothing and towels in the floor. The private bathrooms in both units had strong malodors. One of the sharps containers had razor blades that had been recapped. The Infection Control Preventionist reminded the nurses that razor should not be recapped. Several nail clippers were found to be rusty and were disposed. The Infection Control Preventionist said she would notify the unit Residential Directors/Managers to correct the deficiencies found in the bathrooms. On 5/21/14, the Monitoring Team members comprised of the physician, psychologist, speech/language pathologist, and nurse, accompanied by the CNE and NOO, observed the Direct Support Professionals transfer Individual #126 from the wheelchair into a recliner, and later into the bed. Individual #126 was incontinent of bowel and bladder. Individual #126 was diagnosed as a chronic hepatitis B carrier and had an active Helicobacter Pylori infection that had not been treated. Both of these conditions were communicable. Because of a history of skin breakdown on the buttocks, Individual #126 only wore disposable briefs when using the standing table. Otherwise, an absorbent pad was kept underneath the buttocks. During the transfers Individual #126's clothing and pad were observed to be totally saturated with bodily waste. The staff assisting with the transfer wore protective gloves but did not use other protective gear during the transfers, changing Individuals #126's clothing, and providing perineal care. The staffs' exposed skin and clothing came in contact with the bodily waste, which caused cross-contamination. The wheelchair and recliner were also cross-contaminated. The staff did not appear aware of the significance of the cross-contamination of bodily waste related to contact with their clothing, wheelchair, and recliner as well as the communicability of the above infections. Individual #126's plan only required contact precautions. The CNE immediately contacted the ICF Director and Infection Control Preventionist who came to the unit. Consequently, isolation precautions were promptly put in place. The staffs	

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<tr><td></td><td></td><td>whose clothing were contaminated were sent home to clean up and change clothes to prevent cross-contamination when caring for other individuals, and for their own protection.

<u>Skin Integrity Activities</u>
According to the Facility's Section M Key Indicators Monitoring Data, October 2013 through March 2014, one individual had a Stage II skin breakdown in October 2013, which was healed. There were no other reports of skin breakdown during this time period.

Since the last compliance review, Skin Integrity issues continued to be reviewed and discussed in the Physical Nutritional and Management Team (PNMT) Committee meetings. The Monitoring Team attended the PNMT Committee meeting on 5/20/14 and reviewed the PNMT Committee Meeting Minutes for the past two months. There were no skin integrity issues identified. For additional information regarding the PNMT refer to Section O of the report.

<u>Medical Emergency Response Activities:</u>
The Facility's Self-Assessment Mock Medical Emergency Drill Data, November 2013 through March 2014, analyzed monthly drill results as shown in the chart below:
<table><tr><th>Month</th><th>Number of Passed Drills</th><th>Number of Failed Drills</th><th>Compliance Score</th></tr><tr><td>November 2013</td><td>3</td><td>1</td><td>75%</td></tr><tr><td>December 2013</td><td>7</td><td>0</td><td>100%</td></tr><tr><td>January 2014</td><td>6</td><td>0</td><td>100%</td></tr><tr><td>February 2014</td><td>7</td><td>0</td><td>100%</td></tr><tr><td>March 2014</td><td>5</td><td>0</td><td>100%</td></tr></table>
The Facility's Self-Assessment stated that in January 2014, one drill failed because the nurses did not carry the mock drill phone and receive notification that the drill was called in the Vocational Education Building. The nurses involved were retrained and counseled. Corrective Action Plan: ICF-IID and the Nursing Department agreed to open an active nurses' station at the Vocational Education Building when staffing issues are sufficient. This would benefit the Facility to have a clinician there to do active therapy, treatments, and to be available for emergency situations.

The Facility's Self-Assessment reported the monthly percentage of Emergency Medical Equipment Checklists completed daily by the nursing staff November 2013 through April 2014 as shown in the chart below:</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance

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

Copies of monthly summaries of Emergency Equipment and AED Walkthrough Checklists completed by the Risk Manager/designee were not provided for review for November 2013 through April 2014.

The Monitoring Team checked the emergency equipment and AEDs in El Paisano and La Paloma and found the required emergency equipment to be present and appearing to be in good working order. The nursing staff in El Paisano successfully demonstrated their use. Nursing staff checked the Emergency Equipment and Automated Defibrillators (AEDs) Checklist for May 2014 daily through review date. The equipment was stored securely in the nursing treatment rooms. The nursing staff complained about the instability of transporting the emergency equipment in the Red Ryder wagon and the difficulty with also transporting the portable oxygen tank to the scene of the emergencies. The Facility should evaluate the transportation method used for safety and efficiency. Posters were visibly placed throughout the residential units showing the location of the emergency equipment and AEDs.

A review of the Safety/Risk Management/Infection Control Committee Minutes and Incident Management Review Team Meeting Minutes showed that the results of the monthly drills were reported for review, discussion and disposition.

According to the CTD Due/Delinquent List, eight employees were due/delinquent in CPR Basic Training and eight employees were due/delinquent in BLS for Healthcare Providers. The Facility should ensure that that the due/delinquent employees are retrained as soon as possible.

The positive practices identified in the report should be maintained and improvements made in other areas of practice in order to achieve substantial compliance. This Provision was not found in substantial compliance.

#	Provision	Assessment of Status	Compliance
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 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. <u>Policies, Procedures, Guidelines, and Protocols:</u> Since the last compliance review, there were no new policies, procedures, and/or processes. However, several DADS nursing related policies, procedures, guidelines, and protocols were revised and sent out in December 2013 and January 2014, of which Nursing Administration was not aware. Some of the most significant revisions were made to the DADS SSLC Care Plan Development Guidelines, December 2013 and DADS Guidelines for Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, January 2014. During the compliance review, Nursing Administration was able to access the state office Shared drive for the new/revised policies and guidelines. They will be reviewed and operationalized by the Nursing Department and the nursing staff trained on the revisions. <u>Training Activities:</u> The status of the mandated Physical Assessment and Documentation Class, RN to RN Check-off was not provided for review or listed in the 2013-2014 Nurse Education and Training Database. This training was discussed with the Nurse Educator at the last compliance review who stated she planned to conduct refresher training on this class. It is imperative that all RN Case Managers and RN staff receive this training during New Employee Orientation and at annual competencies refresher training. <u>RN Case Manager Activities:</u> The Nursing Department continued to have a total of four RN Case Managers, two RN Case Managers for each unit, with approximately a 1 to 16 ratio of individuals per RN Case Manager. This ratio appeared to be sufficient to meet the case management requirements. One RN Case Manager had resigned and a new RN Case Manager was hired in February 2014. The RN Case Managers were paired with QIDPs who had mostly the same caseloads and were physically located in the same office. This should enhance the ease of communication between the two disciplines. As was found at the last compliance review, the RN Case Managers were required to attend and participate at the Morning Medical Meetings and present Nursing Referrals.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Nursing Department should ensure that nursing leadership attend the Morning Medical Meetings to ensure that any needed follow up for which the RN Case Managers responsible is communicated to them, including the NOO since she is responsible for supervising the RN Case Managers. The former Quality Assurance Nurse who was now the NOO was responsible for supervising the RN Case Managers. Since assuming this responsibility, the RN Case Manager had made numerous improvements in the case management system, including, but not limited to, monthly RN Case Manager Meetings, training on RN Case Managers responsibilities, and monthly auditing the annual and quarterly nursing assessment for timeliness in completions and for quality of the assessments. Each RN Case Manager was responsible for auditing one of their partner's Annual Nursing Assessments per month for a total of four Annual Nursing Assessments audits. The Facility's Self-Assessment reported Annual Nursing and Quarterly Assessments for timeliness November 2013 through March 2014, as shown in the chart below:	

Key Indicators	November 2013	December 2013	January 2014	February 2014	March 2014
Annual Nursing Assessments	14%	0%	86%	100%	100%
Quarterly Nursing Assessments	NA	NA	81%	71%	71%

The explanation provided in the Facility's Self-Assessment for the low scores is reported in Provision M.1 of the Quality Assurance Activities.

<u>Monitoring Team's Review of Recent Comprehensive Admission/Annual/Quarterly Nursing Assessments:</u>
The Monitoring Team reviewed nine individuals records with high/medium risk conditions selected from both units, Individuals #62, #38, #75, #103, #115, #29, #19, #108, and #126. A review of the Admission, Annual, and Quarterly Nursing Assessments for timeliness, content, and quality found no appreciable improvement from the last compliance review. Findings included:

- Four of four (100%) Admission Comprehensive Nursing Assessments were completed within 30 days of admission. All were completed at least five working days prior to the admission ISP meeting.
- One of two (50%) Annual Comprehensive Nursing Assessments that were due were completed on time, according to Facility policy.
- Two of three (67%) Quarterly Comprehensive Nursing Assessments due were completed on time, according to Facility policy.

#	Provision	Assessment of Status	Compliance
		• Of the nine records provided for review, the following nursing assessment information was missing: ○ Four of eight (50%) of the nursing assessments did not include the quarterly physical assessments that are required by the DADS Guidelines for Comprehensive nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment. Missing Quarterly Physical Assessments included Individuals #75, #115, #29, and #126. In addition, every other page of Individual #75's Admission Comprehensive Nursing Review was not copied for review. As was found at the last compliance review, due to the missing nursing assessment information 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 by the Monitoring Team 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. • It was of concern that Individual #75's admission assessment for End of Life Planning was marked as Do Not Resuscitate (DNR). Individual #75 is a 17 year old female who with the exception of primarily being overweight and having behavioral issues appeared to otherwise be in generally good health. The RN Case Manager/IDT should review the DNR status to determine that it was accurately recorded on the admission assessment. Even though it was apparent from the Monitoring Team's review of the Facility's Assessment information and interview with Nursing Administration, concerted efforts had been made to improve the timeliness and content of the nursing assessment since the NOO took over the supervision of the RN Case Managers. However, a review of the required assessment items found an overall compliance score of 66% as compared to 67% as was found at the last compliance review. Much of the reason for the low overall score was due to the missing assessment information. This showed no appreciable improvement in the quality and content of the nursing assessment. The most essential item that fell below 90% compliance was: • The failure to provide sufficient summaries of individuals' health status progress or lack of progress related to their high and/or medium risk conditions that required nursing services as reported in the Comprehensive Nursing Review, Sections I, II, and III and in the Quarterly Nursing Review Record, Section 9. Often in the sections raw clinical data was provided and/or the goals were listed for the high and/or medium risks without stating the health status progress or lack of progress, or the effectiveness of their respective Integrated Health Care Plans (IHCPs).	

#	Provision	Assessment of Status	Compliance
		In summary, these findings 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. The recently hired CNE and NOO and their plans for restructuring and reorganizing the Nursing Department, along with increased supervision and accountability of the RN Case Managers, provide potential for improvement in compliance with the Provision. The positive practices identified in the report should be maintained and improvements should be made in other areas of practice in order to achieve substantial compliance. 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 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; interviews with the Chief Nurse Executive; Nursing Operations Officer; Unit Nurse Manager, and Nurse Educator, and attendance at an ISP Meeting. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were not in substantial compliance with Provision M.3 and the Monitoring team concurs with their findings. <u>Policies, Procedures, Guidelines, and Protocols:</u> The Nursing Department reported there were no new nursing related policies procedures, processes, or protocols since the last compliance review. The Monitoring Team informed Nursing Administration that numerous new/revised polices and guidelines had been sent out from the state office in December 2013 and January 2014. They stated they were not aware they had been sent out. The Guidelines for Development of Acute Care Planning was most significantly revised. The guidelines discontinued the use of the previous generic care plans and template. The revised guidelines included a new template for developing care plans and a bank of approximately 11 commonly occurring conditions that most often required the development of an Acute Care Plans, from which information could be used to aid in developing plans. Presently, the Nurse Educator was continuing to use the older Acute Care Plans guidelines and generic plans and template. During the compliance review, Nursing Administration was able to access the state office Shared-drive for the new/revised policies and guidelines. They will be reviewed by the Nursing Department and the nursing staff trained on the revisions.	Noncompliance

#	Provision	Assessment of Status	Compliance
		According to Nursing Administration they relied on the Clinic Nurse to notify them when there were acute illness/injury events diagnosed and treated in the clinic that required the development and implementation of Acute Care Plans. The CNE stated they needed to ensure that other means were considered by the nursing staff to ensure all acute illness/injury events were identified and Acute Care Plans and/or relevant nursing protocols were initiated as indicated. Nursing Administration will address this issue with the RN Case Managers and nursing staff. <u>Nursing Department Training Activities:</u> The Nurse Educator provided training on the older version of Acute Care Plan Guidelines. Refer to Provision M.4 for additional information on education and training activities. <u>The Monitoring Team's Review of Acute Care Plans and/or Protocols:</u> The Monitoring Team reviewed seizure records for four individuals who recently had seizure active/status epilepticus for Individuals: #27, #98, #60, and #86. A review of the five Acute Care Plans showed regression in improvement from the last compliance review: Findings included: • Three of four (75%) individuals' most recent seizure activity documentation in either the Integrated Progress Notes or in the Client Work Station (CWS) reports showed the seizure protocol was followed. However, seizure activity reported for three of four individuals were documented in the CWS report but were not documented in the Integrated Progress Notes. The Facility reported following the visit that seizures are documented on the Seizure Record and are only documented in the IPN if additional space for documentation is needed. The documents provided to the Monitoring Team were from the CWS and did not include all the information required to document on the Seizure Record. Nursing Administration should ensure that all seizure activity is documented in the Integrated Progress Notes as well as in the CWS reports. Nursing Administration should enhance monitoring documentation for seizure activity to ensure that the seizure protocol is followed. The Monitoring Team reviewed six recently completed Acute Care Plans and related Integrated Progress for Individuals: #61, #38, #150, #19, #36, and #108. Findings included: • Three of six (50%) Integrated Progress Notes showed that focus assessments were completed promptly for presenting acute illness and/or injuries, as required by relevant nursing protocol. • Six of six (100%) Integrated Progress Notes showed that that the physician was promptly notified and was sent to sick call for presenting acute illness and/or injuries, according to "When Contacting the PCP", and required documentation.	

#	Provision	Assessment of Status	Compliance
		• Four of six (67%) Integrated Progress Notes showed documentation that Acute Care Plans were initiated and the direct support professionals were trained on their responsibilities. • Four of six (67%) Integrated Progress Notes showed documentation that the Infection Control Preventionist was notified of the infection and initiation of antibiotic therapy. • Two of six (33%) Acute Care Plans contained baseline data that sufficiently described what lead up to the necessity for a care plan. • Four of six (67%) Acute Care Plans had realistic, measurable, and/or observable outcome goals related to the acute problems. • One of six (16%) Acute Care Plans were individualized sufficient to meeting the individuals' health care needs. All were copied stock care plans without adequate individualization. • Zero of six (0%) Acute Care Plans incorporated relevant nursing protocols and/or physician orders that required nursing interventions. • Four of six (67%) Acute Care Plans included the frequency for documenting. • Six of six (100%) 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 who were trained. The Facility's process did not include a means to determine whether all DSPs on all shifts who should have been trained actually were. There is no list of DSPs who required training to ensure all are trained. Even though signatures were present it was not possible to determine if all Direct Support Professionals were trained on all three shifts. • Three of six (50%) Integrated Progress Notes showed documentation that the Acute Care Plans and relevant nursing protocols of nursing actions/interventions were followed as described and followed through to resolution. • One of one (100%) Acute Care Plan due for completion contained documented on the plan when it was resolved. • Zero of one (0%) Integrate Progress Notes showed documentation notes when Acute Care Plans and protocols were resolved, as required by protocol. A review of the Acute Care Plans showed some improvement from the last compliance review, but continued improvement is needed to ensure compliance with DADS Guidelines for Acute Care Planning. Now that the Nursing Administration has access to the DADS guidelines for Acute Care Planning, with training of the RN Case Managers and RNs on the guidelines there should be continued improvement found in the development and implementation of Acute Care Plan. Nursing Administration should consider enhanced monitoring of Acute Care Plans and associated documentation in the Integrated Progress Notes.	

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		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. A random review of individuals' "Me Book" included relevant Acute Care Plans. However, all the plans reviewed had been resolved. The Unit Nurse Manager stated that the nursing staff were not allowed to remove the resolved plans from the "Me Books". Nursing Administration should inform the Records Keeping staff when Acute Care Plans are resolved so that they can remove them from the "Me Books". Otherwise, the Direct Support Professional may continue their instructions. <u>The Monitoring Team's Review of Nursing Discharge Summaries and accompanying Discharge Packets:</u> The Monitoring Team reviewed two Nursing Discharge Summaries and accompanying Discharge Packets for Individuals #132, and #149 who were recently discharged into community living. Findings included: • Two of two (100%) Nursing Discharge Summaries or Comprehensive Nursing Assessments were completed within 45 days prior to individuals' move into community living. • Two of two (100%) Nursing Discharge Summaries included individuals' assessments, clinical services' needs, and health status in relation to each significant health clinical indicator, such that the receiving agency could understand their present health status in order to respond to their health care needs. • Two of two (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' preferences. • One of two (50%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' Special Instructions. • One of two (50%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' medications. • One of two (50%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' Immunization Records • One of two (50%) Nursing Discharge Summaries and Discharge Packets contained	

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		documentation regarding review/training provided to the group home nurses on individuals' MOSES/DISCUS, as applicable. • Two of two (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' IRRF. • Zero of two (0%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' IHCP and/or other related health care plans, as needed. • Zero of two (0%) Discharge Packets contained documentation that review/training was provided to the group home nurses on individuals' DSP Instruction Sheets. Nursing Administration should ensure that the RN Case Managers provide training to the group home nurses on the following items, as applicable: Preferences; Special Instructions; Medications list; Immunization Records; current MOSES/DISCUS Assessments; IRRFs, IHCPs, ACPs as applicable, and DSP Instruction Sheets The positive practices identified in the report should be maintained and improvements should be 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. 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 Monitoring Team verified 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, and review of 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. <u>Monitoring Team Findings:</u> <u>New Policies, Procedures, Guidelines, and Protocols:</u> • The Nursing Department reported there were no new nursing related policies procedures, processes, or protocols since the last compliance review. The Monitoring Team informed Nursing Administration that numerous new/revised polices and guidelines had been sent out from the state office in December 2013 and January 2014. Refer to Provision M.3 of the report for more detailed information. • A Restraint Protocol Card was developed. However, the protocol was not consistent with the DADS Policy 001.2 Use of Restraint, April 2014. The CNE stated she would	Noncompliance

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		revise the protocol to be consistent with the restraint policy and would re-train the nursing staff on the protocol. <u>Nursing Education and Training Activities:</u> The Facility's Self-Assessment and Action Plan reported the Nursing Department will start refresher trainings at the monthly nurse's meeting in May 2014. The plan was to cover two protocol cards every meeting and have attending nurses answer a competency-based post-test. The Nurse Educator used the competency-based Nurse Educator Handbook approved by the State Office for annual, refresher, and New Nurse Orientation Training. The Nurse Educator continued to maintain 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 whether they were Facility-employed 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. A review of the fiscal year 2013 through 2014 Nurse Education and Training Database showed the following training courses, percentage of nurses trained, and project completion date for training:	

Tile of Training	Percentage of Completion	Projected date for Completion
Competencies		
New Employee Orientation	100%	Ongoing
ER/Hospitalization	92%	December 2013
Self-Administration of Medication	86%	December 2013
Skin Integrity	73%	May 2014
Documentation/Protocols	85%	May 2014
Pre/Post Sedation	79%	May 2014
Other Trainings		
Precision Glucometer	93%	January 2014
Vagus Nerve Stimulator	67%	December 2013
Mock Drill Phones	60%	December 2013
Professionalism in Work Place	60%	December 2013
Updated Referral Form/Falls	60%	December 2013
Unusual Incident and Abuse, Neglect, and Exploitation	60%	December 2013

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		There appeared to be regression in the required annual core competencies trainings as well as in the percentage of nurses completing training on the topics reported above. In order to achieve compliance with this Provision it is essential that the Nurse Educator ensure that the nursing staff receive competency-based training on all required annual core competencies contained in the Nurse Educator Handbook. The Facility's plan was to conduct training on two competencies, including nursing protocol, each month during the monthly nursing meetings. The Nursing Department should ensure sufficient time is allotted to adequately conduct the monthly training/refresher/competencies as part of their monthly nursing meetings. The core competency-based annual refresher training should not only include didactic instructions but also include a practicum to demonstrate competency in performing the required skills. The adequacy of only training two of the 23 Nursing Protocols monthly at the nurse's meeting was also questionable. It is imperative that the nursing staff are brought up to date on all required trainings. The Nursing Department should check with CTD to ensure that all training provided nurses is entered into permanent training records. The Monitoring Team was not provided Nursing Protocol Tool Audit data analyzed and report by SA-PIC for the last six months; although the Nursing Department stated they had conducted monthly audits on two tools selected for Respiratory Distress/Aspiration and Constipation Protocol Audit Tools. The Monitoring Team was provided two examples of completed audit tools for Annual Nursing Assessments, Respiratory Distress, and Constipation. However, these examples were not analyzed and were too limited to determine the degree of compliance with these tools. The Monitoring Team independently used the set of Protocol Cards to monitor for compliance in records reviewed and reported findings in other relevant Provisions of this report. Record review found lack of adherence to following relevant Nursing Protocols. The nursing staff was observed carrying with them a set of Protocol Cards. Carrying protocol cards makes the information available but does not ensure protocols are put into practice. 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 protocols 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. This Provision was not found in substantial compliance.	

#	Provision	Assessment of Status	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 assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	The Monitoring Team verified the Risk Management information for the Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) processes presented in the Facility's Self-Assessment through: Review of information presented in Section M Presentation Book; review of active records and documents requested; interviews with Chief Nurse Executive, Nursing Operations Officer, Unit Nurse Manager, and Nurse Educator, and attendance at an ISP Meeting. 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 this Provision and the Monitoring Team concurs with their findings. <u>Monitoring Team's Review of IRRF and IHCP Processes:</u> The Monitoring Team's review of the IRRF and IHCP processes showed they were continuing to evolve but were not yet fully proficient in assessing risk ratings and developing integrated health care plans for identified risk conditions. There was no appreciable improvement found in this Provision since the last compliance review. The Monitoring Team reviewed eight most recently completed IRRFs and IHCPs for specific high and/or medium risk conditions requiring nursing services for Individuals #62 for constipation/bowel obstruction, #75 for weight, #126 for constipation/bowel obstruction, #103 for osteoporosis, #29 for infections, #115 for falls, #108 for diabetes, and #19 for urinary tract infections. Findings included: • Eight of eight (100%) individuals' IRRFs had comprehensive interdisciplinary assessments completed. • Four of eight (50%) individuals' IRRF assessments were clinically adequate to support risk levels. • Four of eight (50%) individuals' IRRFs assessments provided clinical data that helped to develop plans to address risk. • Three of eight (38%) individuals' IRRFs risk ratings were developed clinically sufficient to meet the needs of identified risk ratings. Only four of eight (50%) individuals' had IHCPs developed for the identified high risk ratings reviewed. • Three of four (75%) individuals' IHCPs indicated they were approved and implemented by the IDTs within 14 days. • Two of four (50%) individuals' IHCPs met the needs identified by the interdisciplinary assessment. • Two of four (50%) individuals' IHCPs included sufficient preventative interventions to minimize all identified risk ratings. • Two of four (50%) individuals' IHCPs were sufficiently integrated among all relevant	Noncompliance

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		disciplines. • Two of four (50%) individuals' IHCPs contained functional and measurable objectives to measure the efficacy of all plans. • Two of four (50%) IHCPs identified clinical indicators for all risk ratings to be monitored and the frequency for monitoring. • Four of four (100%) individuals' IRRFs and IHCPs were attached to their ISPs. • Zero of four (0%) individuals' IHCPs had Integrated Direct Care Professional Instructions Sheets attached. It was of concern that individuals' with specific high-risk ratings did not have an IHCP developed. Examples of high-risk ratings without an accompanying IHCP included Individual #103 for osteoporosis, Individual #29 for infections, Individual #108 for diabetes, and Individual #126 for constipation/bowel obstruction. According to their IRRFs they had services and supports that were effective. There continued to be the opinion by some of IDTs that if supports and services were in place and effective for the risk conditions that a new IHCP was not necessary. Even if they are effective, for the new ISP year there should be a plan to continue the supports and services. Without a plan, the services and supports cannot be evaluated for effectiveness and may be discontinued or overlooked in the coming year. Of further concern was the lack of sufficient and/or appropriate functional and measurable objectives incorporated into the ISPs to measure the efficacy of the IHCP. For example, this occurred for Individual #62 for constipation/bowel obstruction and Individual #115 for falls. In addition, Individual #115's IHCPs lacked sufficient/appropriate clinical indicators to be monitored and the frequency of the monitoring. Improvements should be made in stating functional and measurable objectives to measure the efficacy, include clinical indicators for all risk ratings to be monitored and the frequency for monitoring, and contain more proactive interventions. . In addition, IHCPs were not consistently developed for medium risk conditions. IHCPs should also be developed for medium risk conditions to mitigate these risk conditions. The Monitoring Team attended Individual #140's ISP Meeting on 5/22/14. Findings included: • The QIDP Facilitator was skillful in eliciting discussion for the IDT members and keeping the IDT focused on the issues being discussed. The new RN Case Manager who lead the IRRF process for the first time and did a good job in facilitating the process. • There appeared to be a lack of consideration of the interrelationship between risk conditions within group as well as the interrelationship between the various group	

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		risk conditions. The IDT, particularly the clinical disciplines, need to exercise more critical thinking in correlating the clinical data from the various groups. For example: o Individual #140 was rated at low risk for dental. Individual #140 had mild periodontal disease and rated at medium risk for respiratory compromise due to a history of mild oropharyngeal swallowing and a diagnosis of dysphagia. Individual #140 required the use of suction tooth brushing. Because Individual #140 required supports for a suction tooth brush due to the periodontal disease and the medium risk for dysphagia, the dental risk rating should have been higher than low risk. Dental should have been considered at least a medium risk. o Individual #140's risk ratings for weight and diabetes were low. She had a history of diabetes and was on an 1800 calorie ADA diet, with clinical indicators for monthly fasting blood sugars via glucometer and annual A1C. The clinical data stated the diabetes was well controlled with the current diet. Although the diabetes was well controlled with diet the risk for diabetes remained. Both weight and diabetes should have been correlated and consideration given to rate both at least medium. After Individual #140's ISP Meeting, the Monitoring Team met with the RN Case Manager and discussed the concerns mention above. The RN Case Manager stated she would review the above risk ratings for dental, weight, and diabetes with the IDT. There appeared to be the opinion of some of the IDT members that if the services and supports that were in place for risk levels were effective, the risk levels were considered low and there was no need for IHCPs. In addition, when considering risk levels, if individuals require services and supports that are not routine for all individuals, the IDT should consider a risk level of medium or high in order to ensure that the IDT will continue to provide effective services and supports. In summary, as was found in past reviews, the IRRF and IHCP processes continued to evolve. As more training is provided and IDT members gain experience 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 positive practices identified in the report should be maintained and improvements made in other areas of practice in order to achieve substantial compliance. This Provision was not found in substantial compliance.	

#	Provision	Assessment of Status	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 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; interviews with the Chief Executive Nurse, Nursing Operations Officer, Unit Nurse Manager, and Nurse Educator; inspections/observations of units' Medication Rooms; review of Units' Medication Administration Record Notebooks, and 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. <u>Medication Administration Policies, Procedures, and Processes:</u> According to the documents provided for review the following Facility's policies, procedures, and processes were reviewed/revised: • RGSC SOP NR 400-08 Nursing Manual, Medication Guidelines, Reviewed/Revised: May 2013. • RGSC SOP NR 400-12 Nursing Manual, Medication Variance Policy, Reviewed/Revised May 2013. <u>Medication Administration Training:</u> New Employee Orientation training documentation listed an aggregate 100% of the nurses received the required medication administration trainings, including the Medication Administration for Individuals with Dysphagia and/or Swallowing Difficulties classes taught jointly with Habilitation Services. <u>Medication Variance Data, Medication Management Workgroup, and Pharmacy and Therapeutics Committee Meetings:</u> The Facility continued to maintain a system for monthly reporting and analyzing medication variances. The Monitoring Team reviewed the past year's monthly ICF Medication Investigation Summary Reports in the Crystal Reporting System. The medication variances data were entered from the Medication Variance Report paper copies and included the investigations of the medication variances. The Investigation Reports describe the medication variances and corrective action taken. The medication variances data were represented as narrative explanations and in tabular 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 reports did not clearly identify the discipline responsible for committing the medication variance. The medication variances were reported for El Paisano, La Paloma, and Inpatient Pharmacy. There were no medication variances reported for medical staff. There was no longitudinal summary provided for the past year's monthly ICF Medication Investigation Summary Reports.	Noncompliance

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		The chart below presents the Facility's Self-Assessment reported Medication Variance Data, November 2013 through March 2014:	

Month	November	December	January	February	March
Total Number of Medications Errors in CWS	6	2	3	10	24
By Category					
A	NA	NA	0	9	12
C	NA	NA	3	1	12
By Location					
1			3	1	6
2			0	0	7
Pharmacy			0	9	11

Medication Management Workgroup Meeting Minutes:

The Monitoring Team reviewed the monthly Medical Management Workgroup Meeting Minutes for 12/17/13, 2/25/14, 3/27/14, and 4/25/14. The meetings were combined with the ICF, Mental Health Hospital, and Out Patient Clinic. Findings included:

- There were no meeting minutes provided for November 2013 and January 2014. The Monitoring Team could not determine whether the meeting occurred or if they were not provided for review.
- One pharmacist and two RNs did not attend the meeting on 5/19/14 during the compliance visit.
- The medication variances for ICF reported in December 2013 meeting minutes for November 2013 were comingled with the Mental Health Hospital variances. Therefore, it was difficult to accurately discern ICF medication variances. There was no discussion or corrective action documented in the minutes for the medication variances. No ICF medication variances were reported in the February 2014, March 2014, and April 2014 minutes. In the April 2014 minutes the Data Analyst described the difficulty with accurately reporting ICF's and the Mental Health Hospital's medication variance in the CWS system. He stated in the future there were going to be four sets of reports—two for ICF and two for the Mental Health Hospital. One of the reports for ICF would be called Investigation Summary. The Nurse Case Managers or designee can log in business objects based on the start and end day entered, and then the reports can be run. The other report will be automatic and would be emailed to respective departments' disciplines, i.e., Mental Health Hospital or ICF, on the 15th of each month, starting on May 15th for the April report. All medication variances need to be completed before the 15th of the month for ICF and the Mental Health Hospital. Hopefully, these reports will improve the accuracy of the

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		medication variance data reported. P&TC Sub-Committee Meeting Minutes: The Monitoring Team reviewed the quarterly P&TC Sub-Committee Meeting Minutes for 1/8/14. Only a copy of the agenda for 3/19/14 meeting was provided for review. The minutes did not report number medication variances. There was a discussion regarding who was responsible for reporting the medication variance data. The action planned was to get direction from the Quality Assurance Director and to split the documentation for medication variances. ICF data will be entered into the Nursing CWS and Mental Health will enter it into the Nursing DSHS CWS. A report was provided on medication room inspection for September 2013 through November 2013. In El Paisano, expired medications were found and returned to the pharmacy. In La Paloma, the medication in the black box was also expired and was replaced. There was no corrective action required. Review of 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 requested for review. Medication Cart Exchange Process: As was found at the last compliance review, La Paloma and El Paisano medication cart exchanges continued to take place in the pharmacy, as opposed to the units. Medication Administration Record Notebooks and medication carts were evenly divided according to census, allowing a ratio of one nurse to 15-20 individuals. Medications in the carts were separated into morning and evening medications. Two nurses from each unit brought the Medication Administration Notebooks along with the medication carts to the pharmacy. 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 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. Nursing SA-PIC Audits Audit of Medication Rooms: The Facility's Self-Assessment's audit data reported to SA-PIC for medication room audits, November 2013 through March 2014 are shown in the chart below:	

Month	November 2013	December 2013	January 2014	February 2014	March 2014
Storage/Sanitation Internal and	100%	71%	85%	76%	81%

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External Separation						
Drug Expiration Dates	100%	71%	85%	76%	81%	
Insulin Administration	90%	96%	96%	81%	94%	
Nursing Supplies and Sanitation	98%	84%	94%	76%	84%	

The medication room audit data as shown above showed some regression as compared to the last compliance review.

<u>Monitoring Team's Audit of Medication Rooms and Medication Administration Record Notebooks:</u>

The Monitoring Team accompanied by the Unit Nurse Manager and/or Floor nurse, used standardized audit criteria consistent with the state's form to audit Medication Rooms and Medication Administration Records and found the following deficiencies:

- In El Paisano the residents' refrigerator had open food, beverage, and thickening containers that were not labeled and dated. These items were immediately removed by the nursing staff. The nursing staff were reminded by the Unit Nurse Manager to ensure that all opened container were dated and labeled.
- In both El Paisano and La Paloma several individuals' Medication Administration Records did not contain their medical diagnosis. The nursing staff were instructed to contact the Pharmacy to ensure that individuals' Medication Administration Records were corrected to include medical diagnoses.
- The pill crushers were not clean in La Paloma.
- The Monitoring Team checked the black tackle boxes that stored medication for return to the pharmacy. It was positive to find since the last compliance review, that few medications were found in the boxes for return to the Pharmacy. All of the medications had completed Pharmacy Excess/Shortage Forms that identified the name of the medication, individuals' name, and reason for return. This aided in the reconciliation of medications to ensure that medications that not reconciled were reported as a medication variance. The Pharmacy picked up the return medications daily. It was of concern that the black tackle boxes were not locked and were sitting on top of the medication refrigerators. This could represent a breach in security. Nursing Administration and the Pharmacy should evaluate the use of unlocked containers for storing returned medications.

<u>Facility's Medication Administration Observation Audit Data:</u>

The Nurse Educator was responsible for conducting Medication Administration Observation Audits. The Nursing Department used the State Office's standardized

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		Medication Administration Observation Form, dated 11/12/13. The Nursing Department followed the statewide Medication Administration Observation Guidelines, which stated observations must only be done for those nurses who routinely administer medications. Medication Administration Observations are scheduled quarterly to ensure all nurses are observed at least once per year. Reducing the observations to only include those nurses that routinely administer medication should facilitate maintaining the required completion of the Medication Administration Observation Audits. The Monitoring Team was provided the results of monthly overall Medication Administration Observation Audit Summaries for October 2013 through March 2014, which are shown in the chart below:	

Month	Oct	Nov	Dec	Jan	Feb	Mar
Medication Observations	100%	100%	100%	100%	100%	100%

Inter-rater reliability checks were not completed for Medication Administration Observations. Although this is not required, the SSLCs monitored by this Monitoring Team conduct such checks to ensure observation findings are consistent. The Facility should consider conducting periodic reliability checks. According to the Facility's Self-Assessment any deficiencies identified during the observations were corrected on the spot. It was questionable that campus-wide the overall compliance scores were consistently 100%, because the review of the actual completed Medication Administration Observation Forms showed a range of compliance from 91% to 100%. However, for items falling below 100% compliance there was documentation that on the spot corrections were made for those items.

It was positive to find that the PNMT staff continued to conduct 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 PNMT's monthly monitoring data for January 2014 through April 2014. Fifteen observations were conducted that showed compliance scores of ranging from 82% to 100%. There was documentation that on the spot corrective action was taken with the nurses who scored less that 100% compliance.

<u>Monitoring Team's Medication Administration Observations:</u>
The Monitoring Team conducted Medication and Enteral Nutrition Administration Observations at El Paisano and La Paloma on 5/20/14 and 5/22/14, accompanied by the Unit Nurse Manager and/or floor nursing staff. The floor nurses administering medication and enteral nutrition continue follow current and generally accepted standards of safe medication administration practices. Findings included:

- Before preparing medications for administration, the nurses consistently reviewed

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		individuals' PNMP 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. Adaptive equipment was available and used for individuals who had such PNMP instructions. 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. • All medications were administered at eye level and in the position stated in the PNMP. • The nurses followed proper handwashing techniques throughout the medication observation passes. • The nurses did not document the medications given until after they were administered. • The nurses consistently told the individuals what medications they were receiving and their purpose. • 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 Support 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 Medication Administration Record Notebooks and medication carts were split in half in La Paloma and El Paisano, so each notebook and medication cart had the information and medications for 15-20 individuals. The morning and evening medications were stored separately in the medications carts. This allowed for efficiency in administering medications, as well as creating a climate free from distractions. The nurses stated these improvements assisted with reducing and/or preventing the potential for medication variances. Nursing Administration stated when nursing staffing is sufficient, two nurses will be administering medications at the same time. This should further improve the accuracy, efficiency, and timeliness of administering medications. • The nurse administering the enteral nutrition followed correct procedures with the	

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		exception of sitting on the individual's bed while instilling the formula. Based on the Monitoring Team's independent review, 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 implemented 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 should be 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 N Self-Assessment: 5/7/2014 2. RGSC Section N Action Plans: 5/7/2014 3. RGSC Section Presentation Book: May 2014 4. Screen shots of the WORx program documenting the current medication list, for Individuals #145, #38, #7, #62, #63, #61, #97, and #118 5. List of QDRRs completed during this reporting period 6. Most recent QDRRs for Individuals #140, $91, #139, #114, #133, #149, #2, #67, #46, #77, #150, #123, #12, #55, #3, #127, and #101 7. Pharmacy and Therapeutics Committee Subcommittee meeting minutes for 1/8/2014, and 3/19/2014 8. Crisis intervention restraint checklist 9. Physician order for Haldol 10mg and Ativan 2 mg for Individual #139 10. Document titled ICF-IDD Client Injuries. 11. Psychotropic polypharmacy meeting minutes for 2/12/2014, 3/4/2014, 3/26/2014, 4/23/2014, and 5/19/2014 12. List of all individuals on polypharmacy 13. For Individuals #31, #33, #114, #133, and #150 a. Most recent psychiatric assessment b. Current medication list c. Most recent IRRF 14. List of single patient drug interventions (SPDI) that occurred during the review period 15. SPDI communication sheets for Individuals #97 and #63 16. MOSES and DISCUS assessments for Individuals #7, #5, #133, #27, #28, #131, #140, $91, #139, #114, #149, #2, #67, #46, #77, #150, and #123 17. Adverse Drug Reporting Forms for Individuals #35, #2, and #145 18. Drug Utilization Evaluation (DUE) schedule 19. Completed DUEs for olanzapine and Benztropine 20. Copies of medication variance reports, and medication error event report for Individuals #19, #140, #63, #134, #46, and one report for an "unknown" individual 21. FY14 Med Variance Data P&T Committee March 19, 2014 **People Interviewed:** 1. Alan Spinner RPh (director of pharmacy) 2. Anne Ikponmwonba, RPh (director of pharmacy) 3. David Moron, MD (Clinical Director) 4. Ramona Rogers, MD (Chair, Polypharmacy Committee) 5. Gary Sauceda (Information Technologist) **Meeting Attended/Observations:**

	1. Psychotropic polypharmacy workgroup meeting, May 19, 2014
	Facility Self-Assessment: Following its review of the Self-Assessment for Section N, the Monitoring Team noted that: • The Facility did not use monitoring/audit tools that relied on sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement. • The monitoring tools did include note sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes. • The Self-Assessment did not identify the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall. The sample sizes, however, were adequate to consider them representative samples. The number or percent of sample size of individuals/records as compared to the overall population was not consistently included in the Self-Assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was not provided by months, quarters, but only provided overall percentage of compliance. • The Monitoring Team determined that the Facility's monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results through inter-rater reliability process completed by the QA department. This was evident by the lack of consistency among the various sections reviewed for this Provision. ▪ It was unknown to the Monitoring Team if sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools; however, based on self-assessments for the past three compliance reports, the outcome of the self-assessment appeared consistent. The Monitoring Team concurred with the Facility's self assessment of noncompliance with Section N.2; however, the Monitoring Team disagrees with the Facility's self-assessment of substantial compliance with Sections N.1 and N3 through N.8, and determined that all sections were not in substantial compliance.
	Summary of Monitor's Assessment: The Monitoring Team recognizes that the Facility had recently hired a new pharmacy director to help develop systems that will better lead the Facility to substantial compliance with Provision N. For this compliance report, the Monitoring Team was concerned that many process that were noted effective during the last compliance review, were no longer effective. For example, the Monitoring Team was required to remove substantial compliance for Section N.1, because documentation that demonstrated the pharmacist's review of new medication orders was not provided; substantial compliance was removed for Section N.4, because there was no standardized and consistent mechanism developed to ensure that single patient drug interventions (SPDI) were implemented when necessary, and evidence was not provided demonstrating SPDI review and follow-up by the medical provider. Furthermore, because there was either lack of documentation provided for review, or processes were not developed and implemented, the Facility did not gain substantial compliance in any other Section for this Provision. For example, many of the QDRRs that were provided were dated prior to this review period, which in turn indicated that QDRRs were not current. In general, the Facility had not enhanced its pharmacy system, to better ensure the safe

	provision of pharmacotherapy at the Facility; as required by the Settlement Agreement. The following are some additional comments and concerns for each Section. **Section N.1:** Because necessary documents were not provided as requested, and because there was no information provided to the Monitoring Team on how to interpret the documents that were provided, the Monitoring Team was unable to assess the status of meeting the requirements of Section N.1, and therefore determined noncompliance. **Section N.2**: The Monitoring Team is very concerned with the overall quality and timeliness of the QDRR process. There were examples of QDRRs not being completed during the review period, despite being required quarterly, and there were examples of no QDRR being completed for some individuals within this review period. Furthermore, the assessment of metabolic syndrome, of use of benzodiazepines, of polypharmacy, and of overall efficacy and appropriateness of medication usage was not fully addressed within the context of the QDRRs. For these reasons, the Monitoring Team determined noncompliance with Section N.2. The Monitoring Team strongly recommends that the Facility develop and implement a standardized process to complete QDRRs. **Section N.3:** The Facility continued to provide a good psychotropic polypharmacy work group meeting that reviewed system issues and provided meaningful clinical reviews of individuals who are proscribed psychotropic polypharmacy; however, the pharmacy department had not consistently participated with the workgroup, and did not provide a comprehensive review of polypharmacy in the context of the QDRR and IRRF processes. Furthermore, the Pharmacy Department did not provide comprehensive assessment of the usage of stat chemical restraint, benzodiazepine, and anticholinergic usage. Because documents were not provided for review, the Monitoring Team was unable to assess the Facility's management of metabolic syndrome. For these reasons, the Facility is not in substantial compliance with Section N.3. **Section N.4:** For the five QDRRs reviewed, the medical providers indicated agreement, and signed the QDRR form. The Facility did not have a standardized, or an effective process to help ensure consistent, and clinically appropriate SPDIs, and for this reason, the Facility is not in compliance with Section N.4. **Section N.5:** The Facility's process to ensure clinically appropriate monitoring for tardive dyskinesia was found to be ineffective. The Facility only recently had begun more frequent assessments to monitor for dyskinesia following a change in neuroleptic dosing; the new electronic assessment forms were disorganized, and not effective for efficacious review of medication side effects. The prescriber did not complete the MOSES and DISCUS assessments as required by each assessment tool. For these reasons, the Facility is not in substantial compliance with Section N.5. **Section N.6:** The Facility had not substantially completed training of all relevant staff on the reporting of ADRs, and did not have a process to review ADRs at a systems level. The Monitoring Team was informed by the clinical, and pharmacy directors that training would be completed by July 2014, and the ADR process would be enhanced.

	Section N.7: The Facility did not provide documentation indicating the development of DUEs for relevant FDA advisories. There was no evidence indicating the development of action plans for identified areas of concerns generated through the DUE process. There was no evidence provided that demonstrated how regularly scheduled DUEs were selected, such as selection through the P&TC meeting or other clinically led committee structure. The Facility's reporting on DUEs, within the context of the P&TC minutes, was ineffective, and there was no indication that action plans were developed to address areas of deficiencies identified by the DUE process. For these reasons, the Monitoring Team determined that the Facility is not in substantial compliance with Section N.7. **Section N.8:** The Facility had recently developed a new process for addressing medication variances, and because the new process had yet to be implemented, the Facility assessed itself in noncompliance for Section N.8. The Facility did not provide necessary documents to complete a meaningful review for Section N.8, and the documents provided, including the March 2014 Medication Data summary for the March 2014 P&TC meeting, did not demonstrate an effective review of the Facility's medication variances. The data and summary of the data were very difficult to interpret, the reports did not clearly identify the discipline responsible for the medication variances, there was no longitudinal summary provided for the past year's monthly ICF Medication Investigation Summary Reports, and there were no specific action plans developed to address systems issues specific to medication variances. For these reasons the Monitoring Team determined that the Facility remains not in substantial compliance with Section N.8.

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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	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 and known allergies, and prompts the pharmacist to review necessary diagnostics. To assess compliance for Section N.1, the Monitoring Team requested copies of the first two new medication orders of each month, for November 2013 through April 2014, for a total of 12 new medication orders. In addition, the following information was requested for each of the 12 examples provided: 1. Pharmacy documentation of a review for allergies, interactions, required diagnostics, appropriate indication, and dose 2. Completed single patient drug intervention reports (SPDI) associated with the new medication order, when an SPDI was necessary. Unlike documents provided for the last compliance review for Section N.1, the Facility	Noncompliance

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	Facility policy or current drug literature.	did not provide examples for the first two new medication orders written for each month during the reporting period. The documents provided for review included screen shots of the WORx program documenting the current medication list, for Individuals #145, #38, #7, #62, #63, #61, and #97. There was no documentation on the copy of the screen shot to indicate what new medication order was initiated, and there was no specific documentation provided for review to indicate that the pharmacists actually reviewed a medication order for indication, appropriate dose, interactions, allergies, and to assess if necessary diagnostics (such as labs, EKG, and ophthalmology exam) were obtained. For the last compliance review, the Facility provided documented evidence of the pharmacist's completion by including a initialed checklist, which was stamped on each new medication order. The stamp included notation for appropriate indication, evaluation of labs, assessment for allergies, and dose. No such evidence was provided for this review, and there was no instruction by the Facility of a new process being developed. Also, when interviewing the pharmacy director, the Monitoring Team specifically asked if there were any new issues specific to Section N.1, and was informed of no changes from the previous process. Within the documents that were provided, there was an inter-department memo, that stated "Cannot provide. I can't obtain new psychotropic, system does not store new data. Even with (Individual #7), (he/she) is new to ICF but came from MH so, there is no new really." This memo indicated that it was specific for Section J.14, and not Section N.1, so the Monitoring Team could not determine its relevance to Section N.1. The Monitoring Team could not determine the relevance of this statement. Conclusion: Because necessary documents were not provided as requested, and because there was no information provided to the Monitoring Team on how to interpret the documents that were provided, the Monitoring Team was unable to assess Section N.1, and therefore determined noncompliance.	
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 requested 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 • 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	Noncompliance

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		• 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 • For the first two individuals from each of the alpha lists provided: the following examples from the alpha lists (Individuals #139, #140, #114, #91, #46, #133, #72, and #27)): 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 As with the last compliance report, the Facility did not provide the requested alpha list of all individuals whose QDRRs were 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 did not clearly indicate if the QDRR was completed as timely. The Facility did not provide specific lists of individuals with diagnoses of hypertension and diabetes and that were prescribed a neuroleptic medication; however, the Facility provided a general alpha list of individuals with such diagnoses, but did not indicate if the individual was prescribed a neuroleptic, or not prescribed a neuroleptic. The Facility did not provide the requested alpha list of all individuals with a diagnosis of seizure disorder, but instead provided an untitled document with the names of individuals, and medications; this list, however, was not specific for individuals with seizure disorder, as many individuals listed did not have a seizure diagnosis, but psychiatric diagnosis listed. For example Individuals #46, #33, and #114 indicated "mood stabilizer" or "Agitation", and no indication of a seizure disorder. The Monitoring Team was concerned that upon reviewing the documents provided for Individual #139, the QDRR for Individual #149 was found among the QDDR sample for Individual #139. When reviewing for side effects to medications, the pharmacist relied upon the MOSES	

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		and DISCUS assessments, and as reported in Section N.5, the MOSES and DISCUS assessments were not completed by the medical provider; therefore, the pharmacist commented on an assessment that was not fully completed, and should have documented this on QDRR, or notified the medical provider to complete the QDRR and MOSES assessments. In addition, the medication listed on the assessments was not an inclusive list of medications provided to the Individual. For example, the MOSES assessment for Individual #139 indicated that the Individual was prescribed lithium, paroxetine, thiothixene, lorazepam, and Seroquel; however, the most recent annual medical assessment indicated that many other medication were prescribed, including levothyroxine, Vistaril, and Miralax, among others. It is important to list all medications because of potential drug-drug interactions that may need to be considered by the medical provider who completes the assessment. <u>Timely Completion of QDRRs:</u> QDRRs were not completed timely. For example, of the eight examples reviewed, three out of eight (63%), were dated prior to this review period: • Individual #140, the QDRR was dated 4/1/2013 • Individual #91, the QDRR was dated 4/18/2013 • Individual #46, the QDRR was dated 8/28/2013 Furthermore, for the five examples with the most recent QDRR dated within this review period, zero out of five examples (0%) included two QDRRs that were completed during the review period. For example: • For Individual #139, the most recent QDRR was dated 1/6/2014; however, no previous or more recent QDRR was provided for review. • For Individual #114, the most recent QDRR was dated 1/7/2014. The Facility did not provide a more recent QDRR. • For Individual #133, the most recent QDRR was dated 3/5/2014; however, the most recent previous QDRR was indicated to be 4/23/2013, a full year, with no interim QDRR's noted. <u>Review of QDRRs</u>: The Monitoring Team requested a total of 12 examples to review; the first two examples from the lists of individuals with diagnosis of hypertension, diabetes, seizure disorder, benzodiazepine usage, anticholinergic usage, and osteoporosis; however, the Facility provided a total of eight examples, and the Monitoring Team could not readily determine which of the requested categories the examples belonged to.	

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		For the eight examples provided for review, only five QDRRs were dated within the time frame of this review period; therefore, only five examples could be fully reviewed for this compliance report. The Monitoring Team found the following: • In zero out of five examples (0%), the pharmacist addressed polypharmacy and included a specific statement indicating the appropriateness of polypharmacy. The QDRR indicated diagnoses, but did not demonstrate review for efficacy, appropriateness for polypharmacy usage. • For the three individuals treated with benzodiazepines, one out of three (33%) 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 five out of five examples (100%). • Metabolic syndrome was appropriately assessed in zero out of the three examples (0%) that required a review for metabolic syndrome. For example: o Individual #139 had diagnoses of diabetes and dyslipidemia, that were well controlled, and was being treated by diet. The QDRR did not include the diagnoses as a risk factor for metabolic syndrome. o Individual #133 was diagnosed with obesity, hypertension, and had a medical plan on the most recent annual medical summary for dysmetabolic syndrome, and was on two neuroleptics. Despite the worksheet for the QDRR indicating that the Individual was at risk for metabolic syndrome, the QDDR did not comment on metabolic syndrome, or offer recommendations to address metabolic syndrome. o Individual #27 was diagnosed with obesity, and was treated for hyperlipidemia, and was on two neuroleptics. Although the QDRR worksheet indicated risk for metabolic syndrome, the QDRR report did not address the important risks associated with being on two neuroleptics. Such risk factors, and the usage of two neuroleptics, should be carefully reviewed by the medical provider, psychiatrist, pharmacist and the IDT, which includes specific notification to the guardian. The only statement on the QDRR was: "metabolic syndrome is under control with current medication although med dosage along with LSM is necessary for dyslipidemia treatment". • The QDRR indicated review by the medical provider in five out of five examples (100%). • The QDRR indicated review by the psychiatrist in five out of the five examples (100%). • MOSES and DISCUS assessments were provided for all examples reviewed; however, none of the MOSES and DISCUS reports indicated completion by the	

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		medication provider, or psychiatrist, by documenting the required physician component of the MOSES and DISCUS forms. Without completion of the physician's component, the assessment is not valid and should not be reviewed by the pharmacist, as part of the QDRR review process. The pharmacist should have noted this issue, and requested that the medical provider or psychiatrist complete the required physician component of each assessment. • The IRRFs reflected all relevant side effects in zero out of the five examples (0%). • 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 three out of five QDRRs (100%) • The QDRR clearly delineated effectiveness of all drugs prescribed in zero out of five examples (0%) • The pharmacists indicated the appropriateness and efficacy of medication usage in zero out of the five examples. The Monitoring Team did note that on the QDRR form, in all cases, there was a checkbox that specifically asked if certain conditions were present, such as polypharmacy, if the individual was free from potential interaction, and if pharmacotherapy appears appropriate. Such issues and conditions require the pharmacists to provide evidence of a clinical review for such conditions, by documenting what clinical indicators were reviewed to make the clinical assessment, and this information was not effectively documented. For example, a review of metabolic syndrome should specifically review known diagnoses associated with metabolic syndrome, and include such conditions as risks factors; as delineated above, the pharmacists did not indicate known diagnoses, such as diabetes, when documenting risks associated with metabolic syndrome. Conclusion: The Monitoring Team is very concerned with the overall quality, and timeliness of the QDRR process. There were examples of QDRRs not being completed in over a year, despite being required quarterly, and there were examples of no QDRR being completed within this review period. Furthermore, the assessment of metabolic syndrome, of use of benzodiazepines, polypharmacy, and of overall efficacy and appropriateness of medication usage was not fully addressed within the context of the QDRR. For these reasons, the Monitoring Team determined noncompliance with Section N.2. To move toward achieving substantial compliance, the Monitoring Team recommends that the Facility develop and implement a standardized process to complete QDRRs.	
N3	Commencing within six months of	Provision N.3 requires that the Facility evaluate its process and usage of stat emergency	Noncompliance

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	the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	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: <u>Review of STAT Chemical Restraint Usage</u>: To assess the Facility's management of stat chemical restraint, the Monitoring Team requested the following documents: • Most recent six months data, trends analysis, and all committee meeting minutes for the systems review of STAT medications used at the Facility • For the most recent six months, all data, trends analysis, and committee meeting minutes for the review of STAT medication use, at the individual level (any and all documentation specific to a clinical review of the use of stat medication by, and for a specific individual/s) • Alpha list of the use of all STAT chemical restraints used at the Facility during the past six month period, and for the most recent ten individuals that received a STAT chemical restraint, please provide o Copy of the Face to Face document that indicates the pharmacist, and psychiatrist review and recommendation of the use of a STAT chemical restraint ▪ If the Facility does not use the Face to Face form, please provide other supporting documentation indicating the pharmacists, and psychiatrists review o Copy of the most recent QDRR The Facility did not provide the Monitoring Team with the documents requested, but provided: • Pharmacy and Therapeutics Committee (P&TC) subcommittee meeting minutes for 1/8/2014, and 3/19/2014 • Crisis intervention restraint checklist • Physician order for Haldol 10mg, and Ativan 2 mg for Individual #139 Review of P&TC subcommittee minutes for 1/8/2014 indicated that the review of stat restraints was tabled, and the minutes for 3/19/2014 P&TC subcommittee indicated that the review of stat medication usage was pending. The minutes included a graph on the usage of stat medication usage, but they did not document a meaningful systems review of stat chemical restraint other then stating "stat medication use at ICF is relatively flat. Uses are for aggression (3), pain (2), agitation (2), and one culture". The associated line graph indicated that five stat chemical restraints were administered during the reporting period.	

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		A Face-to-Face stat chemical debriefing form, which was completed by the prescriber and the pharmacists, was not provided for any other five administered stat chemical restraints that were reported in the 3/19/2014 P&TC minutes; the Facility must ensure that the Face to Face debriefing document, or other mechanism of review, documents the following: • Pharmacist's review of Stat Chemical Restraints • The pharmacist documented a review of scheduled psychotropic medications, and if the scheduled medication dose, formula, or schedule should be changed to help minimize the need for stat chemical restraint. • The pharmacist documented if side effects occurred following the stat chemical restraint. • The pharmacist documented if the indication for the stat chemical restraint was appropriate. • The pharmacist documented if drug and dose used for the stat chemical restraint were clinically appropriate. • The pharmacist documented if currently prescribed pharmacotherapy could be manifesting in the maladaptive behavior resulting in the need for the stat chemical restraint. • Psychiatrist's review of Stat Chemical Restraints: o The psychiatrist documented the clinical rationale for the use of the stat chemical restraint, and if the stat chemical restraint was appropriate or not appropriate. o The psychiatrist documented if side effects occurred following the stat chemical restraint. o The psychiatrist documented if drug and dose used for the stat chemical restraint were clinically appropriate. o The psychiatrist documented if currently prescribed pharmacotherapy could be manifesting in the maladaptive behavior resulting in the need for the stat chemical restraint. o The psychiatrist documented a review of scheduled psychotropic medications, and if the scheduled medication dose, formula, or schedule should be changed to help minimize the need for stat chemical restraint. o The psychiatrist documented review and determination if the behavioral support plan was effective or not effective. Summary: The Facility did not provided an effective systems review for the usage of stat chemical restraint, and clinically appropriate reviews were no completed by the prescribing physician and pharmacist, when stat chemical restraint is administered.	

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		Review of Anticholinergic Drug Usage To assess the Pharmacists' participation in the monitoring of anticholinergic drug usage at the Facility, the Monitoring Team requested the following documents: 1. Past six-months committee meeting minutes, demonstrating a systems review for the Facility's usage of drugs with anticholinergic properties 2. Data, graphs, and data-analysis specific for the pharmacy's monitoring of the use of drugs with anticholinergic properties 3. Alpha list of individuals who are prescribed anticholinergic drugs 4. For the first five individuals on the list of individuals prescribed anticholinergic drugs (Individuals #2, #67, #46, #149, and #101) a. Most recent two QDRRs b. Current medical list c. Most recent medical, and psychiatric annual reviews d. Most recent MOSES and DISCUS assessments The Facility provided a list entitled "Anti-Cholinergics Report", however, as with the last compliance report, the list indicated only the individuals who were prescribed Cogentin and Albuterol, and no other medications with anticholinergic properties. Many other drugs have significant anticholinergic properties and must be assessed by the pharmacy department. The Facility did not provide evidence indicating a systems review for the use of anticholinergic medication usage. Review of QDRRs for anticholinergic review: For the five examples (Individuals #2, #67, #46, #149, and #101), the Facility did not provide the most recent two QDRRs for review; all QDRRs provided were dated prior to this review period. The Monitoring Team did note, however, for the five QDRRs provided, there were no examples of a comprehensive review of all anticholinergic drugs. The Facility must ensure that the following level of review is completed for each QDRR: • The indication for the use of all anticholinergics prescribed is well documented. • The QDRR documented risks associated with the use of anticholinergics. • The pharmacist documented the efficacy, or lack of efficacy, for the use of anticholinergics. Summary: The Facility did not provide evidence of regular systems review for the usage of anticholinergic drugs. The Facility did not provide QDRRs that were completed within the time frame of the current compliance review period. For the QDRRs provided that	

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		were outside the time frame of this compliance review period, none of the QDRRs demonstrated a clinically appropriate review of all anticholinergic drugs. The Monitoring Team is seriously concerned with QDRRs not being completed timely. <u>Assessment of Benzodiazepine usage</u> To assess the Facility's management of the usage of benzodiazepines, the Monitoring Team requested the following documents: • Copy of data, trends analysis, and past six months of committee meeting minutes documenting a Facility systems review for the use of benzodiazepines at the Facility • Copy of data, trends analysis, and past six months of committee meeting minutes documenting review of the use of benzodiazepines, at the level of the individuals (or other documentation demonstrating a clinical review of benzodiazepines for Individuals reviewed during the past six months) • Number of individuals who currently receive scheduled benzodiazepines o Total number o Number receiving benzodiazepines for insomnia related issues o Number receiving benzodiazepines for neurology related issues o Number receiving benzodiazepines for psychiatric related issues o Number receiving benzodiazepines for other related issues • From an alpha list of all individuals who are prescribed a benzodiazepine for a psychiatric indication, provide the following information for the first, and than every second individuals on the list, for a total of five samples: o Most recent QDRR o ISP and/or addendum to the ISP that specifically comments on the use of scheduled benzodiazepine o Current IRRF o Current medication list o List of all injuries that have occurred during the past 6 months, and physician IPN documenting the injury (and potential cause of the injury) o Most recent psychiatric evaluation (documenting the clinical rationale for the use of benzodiazepine) • From an alpha list of all individuals who are prescribed a benzodiazepine for a neurology indication, provide the following information for the first five individuals on the list (please include the actual list) o Most recent QDRR o ISP and/or addendum to the ISP that specifically comments on the use of scheduled benzodiazepine o Most recent IRRF o Current medication list	

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		○ List of all injuries that have occurred during the past 12 months, and physician IPN documenting the injury (and potential cause of the injury) ○ Most recent medical evaluation/or neurology evaluation report documenting the clinical rationale for the use of benzodiazepine The Facility did not provide any relevant documentation to support a regularly scheduled systems review for the usage of benzodiazepines. The Facility did not provide an alpha list of all individuals on scheduled benzodiazepines; however, within the set of documents for benzodiazepine usage, the Facility included a report titled ICF-IDD Client Injuries, and the Monitoring Team was unable to determine the relevance of this document. The Monitoring Team requested five examples for review, and the Facility provided eight examples. Of the eight examples provided, only two QDRRs were dated within the current review period; therefore the Monitoring Team only reviewed two examples (Individuals #139 and #28) and the QDRRs for individuals #77, #150, #123, #12, #55, and #127 were not reviewed. Based on review of the two examples, the Monitoring Team made the following determination: • In zero out of two examples (0%), the QDRR documented the use and indication for the use of the benzodiazepine. • In zero out of two examples (0%), the QDRR documented risks associated with the use of the benzodiazepine. • In zero out of two examples (0%), the QDRR documented efficacy or lack of efficacy for the benzodiazepine. • In zero out of two examples (0%), the QDRR documented recommendations for continued use, along with the clinical rationale for continued use, or consideration for alternative treatments. • In zero out of two examples (0%), risks associated with benzodiazepine usage were clearly delineated on the most recent IRRF. In addition, the Monitoring Team noted the following: ○ The IRRFs did not completely document the risk component for behavioral health. ○ Neither of the two IRRFs included benzodiazepines as a risk for falls. The Monitoring Team provides the following information so the Facility can better understand the Monitoring Teams concern with the completion timeframes for the QDRRs provided for review: 1. Individual #77: No QDRR provided 2. Individual #150: No QDRR provided	

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		3. Individual #123: No QDRR provided 4. Individual #12: QDRR was dated 5/6/2013 5. Individual #55: QDRR was dated 9/19/2013 6. Individual #127: QDRR was dated 8/28/2013 7. Summary: 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, which includes indication, associated risks, efficacy or lack of efficacy, and clinical appropriateness for use. The Monitoring Team is has serious concern that only two out of eight (25%) examples included QDRRs that were completed within the current review period. The Facility must ensure that risks associated with usage of benzodiazepines are documented on the IRRF. <u>Review of polypharmacy usage</u>: To review the pharmacists' participation with assessing the appropriateness of polypharmacy, the Monitoring Team reviewed the following documents: • Psychotropic polypharmacy meeting minutes for 2/12/2014, 3/4/2014, 3/26/2014, 4/23/2014, and 5/19/2014 • List of all individuals on polypharmacy • For the first five individuals on the list of polypharmacy (Individuals #31, #33, #114, #133, and #150) : 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 A list of all individuals prescribed psychotropic polypharmacy was not provided for review. Although the Monitoring Team requested the first five individuals on the list of all individuals prescribed psychotropic polypharmacy, the Facility provided eight examples, and the Monitoring Team reviewed the first five consecutive examples provided by the Facility. It should be noted that for the five examples reviewed (Individuals #31, #33, #114, #133, and #150), only two examples included QDRRs from the current review period, Individuals #133 and #31; therefore, only two examples were reviewed for the pharmacists' inclusion of polypharmacy on the QDRRs: • In two out of two examples (100%) the QDRR documented the indication for the	

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		use of each drug associated with polypharmacy. • In zero of two 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 serious risks associated with prescribed medications must be communicated 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 two examples (0%), the current IRRF assessment documented risks associated with polypharmacy, and relevant monitoring and reporting parameters specific for polypharmacy. • In zero out of two cases (0%), 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 zero out of two cases (0%), the pharmacist documented the efficacy, or lack of efficacy for the use of polypharmacy. The QDRR should document the efficacy, or lack of efficacy for the polypharmacy. As per the last compliance report, the Monitoring Team noted that the Facility's systems review of psychotropic polypharmacy, and the psychotropic polypharmacy workgroup meetings that review psychotropic polypharmacy at the level of the individual, demonstrated a clinically meaningful mechanism to assess polypharmacy; however, the five psychotropic polypharmacy meeting minutes provided for review (2/12/2014, 3/4/2014, 3/26/2014, 4/23/2014, and 5/19/2014) reported a pharmacist was only present for one out of the five meetings (20%), the 3/26/2014 meeting. A pharmacist should be a regular and active participant at the psychotropic polypharmacy workgroup meeting. Infection Control Psychotropic polypharmacy data, and summary of the data that was provided for review was documented on six occasions (12/17/2013, 1/14/2014, 3/14/2014, 4/23/2014, and 5/19/2014) clearly documented polypharmacy usage at the Facility, and categorized the data by the numbers of drugs, specific class of drugs, and specific individual drugs that resulted in polypharmacy. The Monitoring Team could not determine the total rate or percentage of individuals prescribed psychotropic medications who had polypharmacy, as this data was not apparent upon review of the documents. During the reporting period, the Facility indicated that the incidence of polypharmacy increased from 20 individuals being prescribed psychotropic polypharmacy on 12/17/2013 to 26	

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		individuals being prescribed psychotropic polypharmacy on 5/19/2014-- a total of six additional individuals being prescribed psychotropic polypharmacy. The summary of the data stated that the increased number of individuals being prescribed psychotropic polypharmacy was secondary to the new admissions to the Facility, but data were not provided to support this statement. The psychotropic polypharmacy work group conducted specific reviews on a total of 43 individuals during this reporting period. The Monitoring Team observed a polypharmacy workgroup meeting on May 19, 2014, and during that meeting the workgroup reviewed current clinical records, including psychiatric assessments, and documented specific comments and recommendations, which were communicated to the treating psychiatrist for individuals for nine Individuals; the Monitoring Team can not comment on the specific examples because the name key used by the polypharmacy workgroup is different from the name key used for this report. Summary: The pharmacist must provide a clinical opinion as to the rationale and appropriateness of the polypharmacy, document all serious 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 risks associated with the use of polypharmacy and medications in general. The Monitoring Team has serious concerns with the Facility's delay in completing QDRRs. The Facility continues to provide impressive reviews of polypharmacy by the polypharmacy workgroup meeting; however, the pharmacist did not actively participate at most meetings. The polypharmacy workgroup did regularly document and review the overall rate of polypharmacy usage at the Facility. Conclusion: The Facility continued to provide good psychotropic polypharmacy work group meetings that reviewed system issues, and provided meaningful clinical reviews of individuals who are prescribed psychotropic polypharmacy; however, the pharmacy department had not consistently participated with the workgroup, and did not provide a comprehensive review of polypharmacy in the context of the QDRR and IRRF process. Furthermore, the Pharmacy department did not provide comprehensive assessment of the usage of stat chemical restraint, benzodiazepine, and anticholinergic usage. Because documents were not provided for review, the Monitoring Team was unable to assess the Facilities management of metabolic syndrome. For these reasons, the Facility is not in substantial compliance with Section N.3.	
N4	Commencing within six months of the Effective Date hereof and with	To assess the pharmacist's clinical recommendations, and clinical appropriateness of the medical providers' response to the recommendations, the Monitoring Team assessed the	Noncompliance

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	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.	QDRRs used for Section N.2, of this report. In addition, the Monitoring Team requested copies of the first two single patient drug intervention reports completed for each month during the reporting period, for a total of 12 SPDI reports, along with corroborating evidence of the medical providers follow-up on the pharmacists recommendation. As documented in Section N.2 of this report, many of the QDRRs provided were dated prior to this review period, and could not be used for this report, and for this reason the Monitoring Team reviewed the only five QDRRs provided for Sections N.2 and N.3 that were completed within the time frame of this compliance review period (Individuals #133, #139, #28, #31, and #114). The following is a summary of the QDRRs reviewed: o In five out of five examples (100%), the treating medical provider signed and dated the QDRR, indicating a review by the medical provider. o In five out of five examples (100%), the medical provider indicated either accepting or rejecting the pharmacist's recommendation by checking agree or disagree next to each recommendation. o In five out of five examples (100%) the psychiatrist indicated review of the QDRR, when prescribed a psychotropic medication. The Facility did not provide the requested documentation necessary for the Monitoring Team to assess the Facility's SPDI process. The Facility must provide specific documentation that demonstrates that the pharmacist had appropriately identified a clinical issue requiring an SPDI; that the pharmacist documented and informed the prescriber of the SPDI; that the prescriber documented a review of the SPDI; and that there is corroborating evidence, such as a copy of the medical order, or other evidence such as laboratory results, to demonstrate the medical provider's follow-up with the pharmacist's recommendations. The Facility provided several documents, of various different formats, including screen shots of the WORx program, email messages, a handwritten physician communication form, and a document titled "Interventions Facility: RSC – From Date: 9/1/2013 thru Date: 2/28/2014". The copy of the screen shots for the WORx program were for Individuals #61 and #118/ The Monitoring Team could not determine if the required SPDI had been reviewed by the prescriber, and if the prescriber addressed the pharmacist's concern. The email provided for review was for an Individual who was unidentifiable by the Monitoring Team, because the Individual's name and the current name key identifier were not indicated on the email. The email was a notification about a potential drug reaction; however, there was no corroborating information indicating that the prescriber reviewed or addressed the pharmacist's concerns.	

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		The list of interventions documented seven SPDIs. One SPDI was dated prior to this review period, and six were documented between 10/19/2013 and 11/19/2013. There were no SPDIs documented after 11/19/2013. Furthermore, the Monitoring Team could not determine the identity of the individuals listed for the SPDIs, the prescribers did not document their review of the SPDI, and there was no corroborating evidence to indicate that the prescriber followed the pharmacist's recommendations. Two communication sheets were provided for review: • Individual #97: The physician communication form dated 4/30/2014, documented a pharmacy recommendation to "reevaluate continued use daily". The form indicated review by the prescriber, and there was evidence that the prescriber changed the dosing schedule of the medication. • Individual #63: The physician communication form dated 4/30/3024, documented a pharmacy recommendation "Long term coumadin goal for DVT-INR 2/0-3.0 4/23/14 Dr. said to increase Coumadin to 3mg – M, Th, Sa – 9 mg, 2 mg Sun = 11 mg next level not due till 5/20/14. MD actually decreased mg/week. Pt had DVT. Target INR goal should be btw 2.0-3.0 Pls adjust treatment to meet INR goal (2/5-3.0)." The Monitoring Team found it very challenging to interpret the recommendations. The prescriber did not indicate agreement or disagreement, and did not sign the physician communication form as required. Conclusion: For the five QDRRs reviewed, the medical providers indicated agreement, and signed the QDRR form. The Facility did not have a standardized or effective process to help ensure consistent and clinically appropriate SPDIs and physician responses. For these reasons, the Facility is not in compliance with Section N.4.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	To assess the Facility's 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. For Section N.5, the Monitoring Team requested the MOSES and DISCUS assessment that were obtained following a change in dose, or new order for neuroleptic class of drugs. The Facility indicated on the document request form that a total of eight individuals met the criteria; however the Facility only provided six examples (Individuals #7, #5, #133, #27, #28, and #131). The following are the Monitoring Teams concerns, and comments for the review of MOSES and DISCUS assessments: • Zero of six MOSES and DISCUS assessments provided for review (0%) included a physician review section. The DISCUS assessment requires that a physician	Noncompliance

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		review the form, and indicate if Tardive Dyskinesia is present or absent. • There was no indication of a signature, or an electronic signature, for the medical prescriber's review. • The assessments only listed psychiatric medications, and did not list all of the medication. Because of drug-drug interactions, and clinical effects of other drugs, all drugs must be clearly delineated on the form. • The Facility provided the new electronic versions of the DISCUS and MOSES assessments, and they were all noted to be printed in a way that resulted in challenges for the Monitoring Team assessment of the printed forms. For example, the electronic MOSES assessment report was eight pages long, instead of one page for the original version; assessment categories were abruptly terminated on one page, and continue on the subsequent page, but without a header explaining what was being assessed; and in some occasions, such as for the MOSES dated 4/24/2014 for Individual #7, a scoring scale would be printed between the items assessed for each category. This would make assessment difficult for the Facility as well as for the Monitoring Team. • All examples provided were dated 3/26/2014 through 4/25/2014. There were no other examples provided for medication changes prior to 3/26/2014. During the on-site interview with the clinical director, the Monitoring Team was informed that the Facility had only recently started to ensure that more frequent MOSES and DISCUS assessments were obtained when clinically necessary. In addition to the five examples reviewed, the Monitoring Team reviewed many other MOSES and DISCUS assessments for Sections N.2 and N.3 of this report, and the same concerns as determined for Section N.5 were noted when reviewing those sections. The Facility reported that it had recently implemented the new electronic MOSES and DISCUS reporting system, and during their own internal review had noted that several electronic MOSES and DISCUS reports had not included the physician review section, or included electronic signatures. After the Monitoring Team provided a draft report, the Facility provided copies of handwritten MOSES and DISCUS forms that were completed and signed by the prescriber for Individuals #5, #27, #28, #46, #60, and #139. The Monitoring Team reviewed these and found: • Nine of 15 (60%) DISCUS reports were appropriately completed by the medical provider. • Twelve of twelve (100%) MOSES reports were appropriately completed by the medical provider.	

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		Conclusion: The Facility's process to ensure clinically appropriate monitoring for dyskinesia was found to be ineffective. The Facility only recently had begun more frequent assessments to monitor for dyskinesia, following a change in neuroleptic dosing; the new electronic assessment forms were noted to be disorganized, and not effective for efficacious review of medication side effects; the MOSES and DISCUS assessments were not completed by the prescriber, as required by for each assessment tool. For these reasons, the Facility is not in substantial compliance with Section N.5.	

N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	To assess the Facility's adverse drug reaction (ADR) process, the Monitoring Team requested the following documents:
		• List of all ADRs that occurred during this reporting period
		  o Name of individual
		  o Type of ADR
		  o Date ADR occurred
		  o Date ADR initially reported
		• Copy of all data, data analysis, and past six months committee meeting minutes documenting a systems review specifically for ADRs at the Facility
		• Copy of policy/procedures specific to staff training on ADRs
		• List of all staff who have received specific training on identifying, and reporting of ADRs for each group (please be specific)
		  o Direct care support staff
		  o Pharmacists
		  o Nurses
		  o Medical prescribers
		  o Other
		• List of all staff who have not received specific training on identifying, and reporting of ADRs
		  o Direct support professionals
		  o Nursing
		  o Pharmacists
		  o Medical prescribers
		  o Other
		• For the first, and every second, ADR reported during this review period, for a total of ten ADRs:
		  o Copy of all ADR related forms completed
		  o 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)
		  o Copy of all medical orders specific to the ADR (such as d/c
			Noncompliance

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		medication, alternate medication, laboratory studies, etc) o Copy of all related nursing IPNs specific to the ADR and monitoring of the ADR o Copy of the pharmacist's review of the ADR, and recommendations o Copy of the IDTs notification of the ADR (including notification to the guardian) Review of the documents provided: • The Facility did not provided a list indicating all staff that had been trained on the ADR process. During the on-site meeting with the pharmacy director, the Monitoring Team was informed that the Facility had recently developed a training venue and all nurses will be expected to be trained on the ADR process by July 30, 2014. Furthermore, the Monitoring Team was informed that medical providers were instructed on the ADR process during a medical executive meeting, and such instruction will be incorporated into the medical provider's orientation book; however, no evidence was provided to support this effort. • The Facility did not provide evidence of a systems review for ADR that occurred at the Facility • The Facility indicated that only three ADRs occurred during the reporting period (Individuals #35, #2, and #145); however, the Facility did not provide all of the requested documentation to support a clinically effective review of ADRs, that occurred during the review period. For example: o Medical provider, and nursing IPNs to address the clinical issues associated with the ADR were not provided. For example, Individuals #2 and #145 were suspected of developing serious side effects to neuroleptics, and there were no IPNs provided for review. o The physician, for the three examples provided, did not complete the physician sections of the ADR report forms. o There was no documentation provided to indicate review by the P&TC, as required by the form. o There was no documentation provided indicating that the guardian was made aware of the ADRs. For example, Individual #145 was transferred to the emergency department for assessment secondary to a possible ADR, and in this case the guardian should be made aware that the triage to the emergency department was for a suspected ADR; no evidence was provided to indicate that this was done. The guardian should be made aware of all medical interventions associated with an ADR or suspected ADR.	

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		Conclusion: The Facility had not substantially completed training of all relevant staff on the reporting of ADRs, and did not have a process to review ADRs at a systems level. Training on ADRs, and a process review of the number and types of ADRs being reported at the Facility are integral components of an effective ADR process. Furthermore, all three of the reporting forms provided for review were not completed as required by the form. For these reasons the Facility is not in substantial 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: 1. Copy of DUE scheduled (past 12 months and pending 12 months) – the schedule must include a. All scheduled DUEs b. All completed DUEs c. All pending DUEs d. All follow-up to DUEs e. All impromptu DUEs provided secondary to Facility concern f. All DUE provided because of FDA advisory 2. List of all DUEs provided in past six months a. Type of DUE (Scheduled, FDA advisory, clinical concern, etc) b. Copy of DUE materials c. Copy of all communications/notifications per the pharmacists for each DUE d. Documentation of the action plan to address issues raised by the DUE and i. Evidence to support that such action plan was implemented ii. Evidence to support efficacy of the action plan e. Attendance records for all scheduled DUEs <u>DUE Schedule:</u> The Monitoring Team was provided a list titled DUE Schedule for 2013-2014. The list included four DUEs that were either completed or were pending completion, and indicated if the DUE was a scheduled DUE, associated with a clinical concern, or secondary to an FDA advisory. The following is the information documented on the DUE schedule: • Fluoxetine – June 2013 to August 2013; scheduled; complete • Benztropine – September 2013 to November 2013; scheduled; complete • Olanzapine; - December 2013 to February 2014; scheduled; complete • Diphenhydramine – March 2014 to May 2014; clinical concern; pending	Noncompliance

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		completion • Pending trend analysis/FDA advisory - June 2014 to August 2014; suggestions anticonvulsants, antianxiety, or analgesic to be discussed at the next P&T meeting • High Risk Med: secondary to Facility Concern o Quarterly; Coumadin o June 2013 –August 2013; complete o September 2013 –November 2014; complete o December 2013 – February 2014; complete o April 2014 – May 2014; last updated Quarterly Feb 2014. Next due after May's collection <u>Review of P&TC minutes:</u> 1. The Facility did not provide a copy of P&TC minutes documenting the P&TC's selection of scheduled DUEs for the calendar year. 2. The Facility provided P&TC minutes dated 3/19/2014. a. The minutes documented a summary for the olanzapine and Coumadin DUEs. There was no evidence provided that the P&TC reviewed the DUE for Benztropine, which was reported to have been completed during this review period. b. P&TC documentation for the DUE did not indicate follow-up action plans for identified issues per the DUE. The documentation format was ineffective and confusing to readers other then P&TC members. For example, the P&TC minutes documented the following review for olanzapine: "Pt. Monitoring Parameters compliance % 50% (8). 2 fell out due to BMI measurement – when a new antipsychotic is initiated, at every visit (mthly) for 6 months after the new antipsychotic is initiated and qrtly. When the antipsychotic dose is stable. 2 fell out due to EPS evaluation before imitation of any antipsychotic med. Then weekly for the 1st2weeks after initiating text with a new antipsychotic or until the dose has been stabilized and weekly for 2 weeks after a dose increase. 4 fell out due to Tardive dyskinesia evaluation- q 12 month. For high risk patient (including the elderly) every 6 months. Dosage Guidelines 100%". <u>Review of completed DUEs</u>: The Facility provided medical staff summaries for DUEs provided for olanzapine and Benztropine. The DUE for olanzapine indicated that eight monitoring parameters were not met, and one contraindication was identified. In no cases were action plans documented to address the deficient monitoring parameters or contraindication; if developed, they were	

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		not included as a component of the DUE. The DUE for Benztropine indicated that two monitoring parameters were not met, and seven contraindications were identified. In no cases were action plans documented to address the deficient monitoring parameters, or contraindication; if developed, they were not included as a component of the DUE. <u>Review of DUE developed for FDA advisories:</u> There was no documentation provided indicating the development and implementation for relevant FDA advisories that were issued during this reporting period. For example, the following FDA advisories were issued for the following medications, which are common to the practice of either psychiatry, or general medicine: • Acetaminophen prescription combination drug products with more than 325 mg • Testosterone products; risk of cardiovascular events • Rosiglitazone containing diabetes medicines; drug safety communication • Methylphenidate ADHD Medications; drug safety communication The Facility should ensure that documented reviews for relevant FDA advisories are initiated at the Facility, and that the FDA advisories are well communicated to the pharmacy and medical staff, regardless if the medication is currently prescribed to an individual at the Facility. The DUE process is an effective mechanism to ensure that important clinical concerns regarding current standard of care pharmacotherapy are communicated to the necessary clinical staff. Conclusion: The Facility did not provided documentation indicating the development of DUEs for relevant FDA advisories. There was no evidence indicating the development of action plans for identified areas of concerns generated through the DUE process. The was no evidence provided that demonstrated how regularly scheduled DUEs were selected, such as selection through the P&TC meeting, or other clinically led committee structure. The Facility's reporting on DUEs, within the context of the P&TC minutes, was ineffective. For these reasons, the Monitoring Team determined that the Facility is not in substantial compliance with Section N.7.	
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	To assess the Facility's medication variance process, the Monitoring Team requested the following documents: • 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	Noncompliance

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	action regarding actual and potential medication variances.	• 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:
		  a. Copy of medication variance reporting forms
		  b. All physician IPNs associated with the medication variance
		  c. All nursing IPNs associated with the medication variance (initial assessment, and through the monitoring period for the medication variance)
		  d. All pharmacy documentation, and communication related to the medication variance
		  e. All IDT minutes specific to the medication variance
		  f. Documentation that the guardian was made aware of the medication variance (for category C or worse)
		
		The Facility provided the Monitoring Team with the following documents:
		• Copies of medication variance reports, and medication error event report for Individuals #19, #140, #63, #134, #46, and one report for an "unknown" individual.
		• FY14 Med Variance Data P&T Committee March 19, 2014
		• P&TC Sub-Committee Meeting Minutes for 1/8/14
		
		Because of the overlap between Sections N.8 and M.6, the following review incorporates findings noted in M.6 of this report, and refers the reader to Section M.6, for further information regarding medication variances.
		
		<u>Medication Variance Data and Medication Management Workgroup and Pharmacy and Therapeutics Committees Meetings:</u>
		The Facility continued to maintain a system for monthly reporting and analyzing medication variances. The Monitoring Team reviewed the past year's monthly ICF Medication Investigation Summary Reports in the Crystal Reporting System. The medication variances data were entered from the Medication Variance Report paper copies and included the investigations of the medication variances. The Investigation Reports describe the medication variances and corrective action taken. The medication variances data were represented as narrative explanations and in tabular charts. Data were reported for severity index categories, whether the errors reached the individuals, day of week the medication errors occurred, medication process, type, cause, location and total medication errors/variances by location. The reports did not clearly identify	

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		the discipline responsible for committing the medication variances. The medication variances were reported for El Paisano, La Paloma, and Inpatient Pharmacy. There was no medication variance reported for medical staff. There was no longitudinal summary provided for the past year's monthly ICF Medication Investigation Summary Reports. The chart below presents the Facility's Self-Assessment reported Medication Variance Data, November 2013 through March 2014:	

Month	November	December	January	February	March
Total Number of Medications Errors in CWS	6	2	3	10	24
By Category					
A	NA	NA	0	9	12
C	NA	NA	3	1	12
By Location					
1			3	1	6
2			0	0	7
Pharmacy			0	9	11

Medication Management Workgroup Meeting Minutes:

The Monitoring Team reviewed the monthly Medical Management Workgroup Meeting Minutes for 12/17/13, 2/25/14, 3/27/14, and 4/25/14. The meetings were combined with the ICF, Mental Health Hospital, and Out Patient Clinic. Findings included:

- There were no meeting minutes provided for November 2013 and January 2014. The Monitoring Team could not determine whether the meeting occurred or if they were not provided for review.
- One pharmacist and two RNs did not attend the meeting on 5/19/14 during the compliance visit.
- The medication variances for ICF reported in December 2013 meeting minutes for November 2013 were comingled with the Mental Health Hospital variances. Therefore, it was difficult to accurately discern ICF medication variances. There was no discussion or corrective action documented in the minutes for the medication variances. No ICF medication variances were reported in the February 2014, March 2014, and April 2014 minutes. In the April 2014 minutes the Data Analyst described the difficulty with accurately reporting ICF's and the Mental Health Hospital's medication variance in the CWS system. He stated in the future there were going to be four sets of reports—two for ICF and two for the Mental Health Hospital. One of the reports for ICF would be called Investigation Summary. The Nurse Case Managers or designee can log in business objects based on the start and end day

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		entered, and then the reports can be run. The other report will be automatic and would be emailed to respective departments' disciplines, i.e., Mental Health Hospital or ICF, on the 15th of each month, starting on May 15th for the April report. All medication variances need to be completed before the 15th of the month for ICF and the Mental Health Hospital. Hopefully, these reports will improve the accuracy of the medication variance data reported. <u>P&TC Sub-Committee Meeting Minutes:</u> The Monitoring Team reviewed the quarterly P&TC Sub-Committee Meeting Minutes for 1/8/14. Only a copy of the agenda for 3/19/14 meeting was provided for review. The minutes did not report number medication variances. There was a discussion regarding who was responsible for reporting the medication variance data. The action planned was to get direction from the Quality Assurance Director and to split the documentation for medication variances. ICF data will be entered into the Nursing CWS and Mental Health will enter it into the Nursing DSHS CWS. A report was provided on medication room inspection for September 2013 through November 2013. In El Paisano, expired medications were found and returned to the pharmacy. In La Paloma, the medication in the black box was also expired and was replaced. There was no corrective action required. <u>Review of Completed Medication Variances:</u> The Facility did not provide an alpha list of all medication variances that occurred during the reporting period, but provided a list that was not labeled, with a hand written statement indicating the list is of variances that occurred since the Facility started its new medication variance process. The list documented 20 medication variances, for 12 unique individuals occurring since 1/17/2014. • The list was not an alpha list, but individuals were lists by category of medication variance • The following variance were reported: o Documentation: 3 o Administration: 8 o Transcribing: 7 o Dispensing: 1 o Other: 1 • Eight of the 20 omissions were classified as category C. The Monitoring Team requested the first and than every second individual from a list of all individuals who experienced a medication variance during the compliance review period, for a total of ten examples. The Facility only provided examples for five individuals (Individuals #19, #140, #63, #134, and #46).	

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		Some of the reports provided were titled as medication error reports, while others were titled medication variance reports. The Facility did not provide medical provider IPNs to address the clinical issues associated with the medication variance. For example, Individual #19 missed a seizure medication, and there were no IPNs provided that documented by medical providers for this issue. Onsite meeting with clinical director and pharmacy director: The clinical director and pharmacy director informed the Monitoring Team that the Facility was not in compliance with Section N.8, and that they were in the process of redeveloping the medication management program at the Facility. Conclusion: The Facility had recently developed a new process for addressing medication variances, and because the new process had yet to be implemented, the Facility determined noncompliance for Section N.8. The Facility did not provide necessary documents to complete a meaningful review for Section N.8, and the documents provided, including the March 2014 Medication Data summary for the March 2014 P&TC meeting, did not demonstrate an effective review of the Facility's medication variances. The data and summary of the date were very difficult to interpret, the reports did not clearly identify the discipline responsible for the medication variances, there was no longitudinal summary provided for the past year's monthly ICF Medication Investigation Summary Reports, and there were no specific action plans developed to address systems issues specific to medication variances. For these reasons the Monitoring Team determined that the Facility remains not in substantial compliance with Section N.8.	

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-Assessment, dated 5/7/2014 2. RGSC Action Plan 5/7/2014 3. RGSC Policy 500-02 Physical and Nutritional Management Policy (revised 7/2013 and reviewed 3/2014) 4. RGSC Policy 400-19 Minimum Common Elements of Care (reviewed 3/2014) 5. RGSC Policy 400-02 At Risk Individuals (reviewed and revised 3/2014) 6. Physical and Nutritional Management Team (PNMT) Monitoring Process (revised 12/2013) 7. Settlement Agreement Monitoring Tool for Section O 8. Key Indicators-Section O (not dated) 9. Trigger Process (revised: 4/28/2014) Record reviews: 10. Sample O.1: Individuals #5, #19, #33, #46, #60, #77, #103, and #145, 11. Sample O.2: Individuals #79 and #126 12. Sample O.3: Individuals #19, #79, and #126 13. Sample O.4: Individuals #2, #19, and #115 14. 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 15. New PNMT members since last review, including a copy of their curriculum vita 16. Caseloads of PNMT dedicated and non-dedicated members 17. 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 18. Quality Assurance (QA) reports/matrix since the last compliance review 19. List of referrals to the PNMT since the last compliance visit 20. PNMT RN post hospitalization assessments completed since the last compliance visit 21. PNMT assessment template 22. PNMT Action Plan template 23. IRRF template 24. IHCP template 25. Compliance Monitoring Form guiding questions sheet 26. List of new employees since last compliance visit and their PNM related performance check offs 27. 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) 28. Facility documentation showing categories of staff requiring annual refresher training, numbers of staff requiring training, and numbers of staff who have successfully completed training; 29. PNM Monitoring Tool template 30. Last three months of PNM monitoring data (including date, activity monitored, time of monitor, person conducting monitor) 31. For Individuals in Samples 0.1 to 0.4: 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. QIDP 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:** 1. Jane Augustine PT Director of Habilitation Services 2. Belinda Lopez SLP 3. Sotera Villalpando SLP 4. Victor Wilson OT 5. Betty Perez Rehab Tech II 6. Marcy Valdez RN 7. Six direct care staff (3 La Paloma, 3 El Paisano) **Meeting Attended/Observations:** 1. PNMT meeting 5/20/2014 2. Morning Medical 5/20/14 3. Mealtimes and Transitions (La Paloma, El Paisano) 4. Vocational Education
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, dated 5/7/2014, and Action Plan dated 5/7/2014. 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 state the staff/positions who were responsible for completing the audit tools; therefore there was 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. The Facility rated itself as being in compliance with Provisions O.1, O.2. O.6, O.7, and O.8. This was consistent with the Monitoring Team's finding of compliance with Provisions O.1, O.3, O.5, and O.8 and inconsistent with the Monitoring Team's findings of noncompliance with Provisions O.2, O.6, and O.7. The Action Plans developed were felt to move RGSC in the right direction towards compliance. RGSC should continue to review the findings of the Monitor's report and revise the Action Plans as indicated to address all identified concerns. All criteria identified as part of the provision requirements were not represented as part of the self-assessment. Methods to gauge quality and not just presence should be investigated and integrated as part of the Action Plan. Additionally, many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: Overall, RGSC appeared to moving in a positive direction with regards to providing physical and nutritional services. Improvement was evident with the Physical and Nutritional Support Plans (PNMPs) as they were noted be more comprehensive. Another improvement noted was sharing of information between the PNMT and the IDT. Concerns continued regarding the lack of implementation of plans of care as well as how well the PNMT assessment comprehensively reviewed and provided root analysis of PNM issues. Provisions O.1 and O.3 were found in substantial compliance. Specifics regarding compliance and noncompliance are listed below in the summary and within each provision. **Provision O.1:** This provision was determined to be in substantial compliance. The PNM policy had been

	revised and represented all components. PNMT members attended the meetings regularly and received sufficient education to assist in performing the job duties. **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 in substantial compliance. PNMPs were much improved and were contained the areas needed to address PNM issues. PNMPs were updated in a timely manner and were consistent with other plans of care (i.e., IRRFs). **Provision O.4:** This provision was determined to be not in compliance. Staff was observed not consistently implementing PNMPs and displaying safe practices that minimize the risk of PNM decline. Individuals were not consistently provided with safe dining strategies. **Provision O.5:** This provision was determined to not be in compliance. All staff, new and existing, received both foundational as well as individual-specific training. Greater than 90% of staff had received all necessary training provided through new employee orientation as well as annual refresher courses. Concern was regarding Individual specific training as it was not provided in a timely manner. **Provision O.6:** This provision was determined to be not in compliance. While the monitoring system showed signs of improvement, all areas and times in which swallowing problems were likely to be provoked were not monitored as needed. **Provision O.7:** This provision was determined to be not in compliance. There was a lack of evidence of indicators being integrated as part of the Integrated Health Care Plans (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). The QIDP monthly reviews if completed only stated if changes were made to the PNMP and provided no information regarding status of the individual or if the individual had any issues related to PNM. **Provision O.8:** This provision was determined to be in substantial compliance. Return to oral intake was included as part of the Habilitation Assessment and there was a clear determination of whether the individual was a candidate for an oral motor treatment program to improve potential for by mouth (PO) intake.

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O1	Commencing within six months of the Effective Date hereof and with	The following samples were utilized for Section O:	Substantial Compliance

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	full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have	Sample O.1 consisted of a non-random sample of eight individuals who were chosen from a list provided by the Facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight [over 30 or under 20 BMI], enteral nutrition, GI, osteoporosis], require mealtime assistance and/or are prescribed a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. Sample O.2 consisted of two individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. Sample O.3 consisted of three individuals at RGSC who received enteral nutrition. Sample O.4 consisted of three individuals identified by RGSC as receiving oral motor therapy <u>PNM Policy and Role of the PNMT:</u> The Facility did 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;	

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	specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	• Discharge criteria from the PNMT; • Assessment process; • Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; • The PNMT consultation process with the IDT; • Method for establishing triggers/thresholds; • Evaluation process for individuals who are enterally fed; • PNMT follow-up; • Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; • A comprehensive PNM monitoring process designed to addresses all areas of the PNMP, including: 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):	

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		○ A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan). ○ Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary and ○ If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate to measure the resolution of systemic issues. Based on interview with the Director of Habilitation Services 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 fulltime PT and one OT on staff; therefore a backup was not available. <u>Consultation with Medical Providers and IDT Members</u> For one of two individuals in Sample O.2 (50%), evidence was provided of routine participation of medical staff in meetings, review of assessments, and other needed activities. There was no evidence of active participation by the physician as part of the PNMT process although Individual #126 had a history of and was currently experiencing multiple underlying medical issues. This is discussed further in Section O.2. 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 PNMT members and all back up members (100%) were licensed to practice in the state of Texas. Five of five core PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. <u>Continuing Education</u> Five of five PNMT staff (1000%) 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 since the last compliance visit, the following core PNMT members earned continuing education units in relation to population as follows:	

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PNMT Member	Date	Course Title	Hours
PT	10/31/2013-11/01/2013	SSLC Annual Habilitation Therapies Conference: Issues in Evaluation & Treatment of Individuals with Developmental Disabilities	12.5
	03/21/2014	Fall Prevention	6
PNMT RN	10/31/2013 - 11/01/2013	SSLC Annual Habilitation Therapies Conference: Issues in Evaluation & Treatment of Individuals with Developmental Disabilities	12.5
SLP #1	10/31/2013-11/01/2013	SSLC Annual Habilitation Therapies Conference: Issues in Evaluation & Treatment of Individuals with Developmental Disabilities	12.5
RD	11/07/2013	Type 1 Diabetes: A Review of Current Management Strategies	1
	11/14/2013	The Role of Nutrition in Pressure Ulcer Management	1
	11/20/2013	Ethics in Nutrition Support	1
	01/29/2014	Diabetes Management: Strategies for an Aging Population	1
	02/12/2014	HHSC Nutrition & Food Service Regional Meeting for State Hospitals and State Supported Living Centers	5.5
OT	03/21/2014	Fall Prevention	6

PNMT Meetings

Below is the PNMT attendance summary as reported by the Facility and documented in the meeting minutes:

Discipline	Oct	Nov	Dec	Jan	Feb	Mar	Total # Mtg Attendance	Total % Attended
# Meetings	4	4	4	4	4	4	24	
PNMT RN	4/4	4/4	4/4	4/4	4/4	4/4	24	100%
PT	4/4	4/4	4/4	4/4	4/4	4/4	24	100%
SLP/Alt	4/4	4/4	4/4	4/4	4/4	4/4	24	100%
RD/Alt	3/4	4/4	4/4	4/4	4/4	4/4	23	96%

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OT	4/4	4/4	4/4	4/4	4/4	4/4	24	100%
Total %								99%

From 11/2013 to 3/31/13, the PNMT met a minimum of weekly.

Core members of the PNMT were consistently present for at least 80% of the meetings. As noted above, actual participation was above 95%.

Twenty-four of 24 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 have a sustainable system fully implemented for resolution of systemic issues/concerns. Included in the system was:

- How Habilitation Therapies and the PNMT identified and presented systemic issues requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Morning Medical Report meeting, QA/QI meeting).

The PNMT had recently begun utilizing key indicators, which were tracked monthly and reported on a quarterly basis as part of the SAF-PIC meeting. An example of the key indicators included:

- Number of choking events that occurred due to wrong texture
- Number of individuals who transitioned form enteral to oral intake

Reviews of the indicators were also scheduled to be included as part of the PNMT meeting. Discussion of the indicators had not yet occurred so this will be a process that will be reviewed during the next visit.

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	<u>Identification of PNM risk</u> Sixty-three of 63 individuals (100%) who cannot feed himself or herself, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems") had a PNMP. The Facility did 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").	Noncompliance

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	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.	Six of 10 individuals in Samples O.1 and O.2 (60%) were provided with an accurate risk score related to all of the PNM risk areas (i.e., respiratory compromise, GI, skin breakdown, falls, fractures, aspiration, and choking, or others relevant to specific individuals). Issues with risk scores focused on the accuracy in which individuals were identified. Examples in which risk was not accurately identified included: ▪ Individual #5 had a history of pharyngeal residue, premature spillage and at times would steal non-recommended food items but was only listed as being at a medium risk of aspiration. ▪ Individual #145 had the second largest number of falls over the past six months and was rated as high risk for falls but was listed as low risk for fractures. Other individuals noted through observations who were not appropriately risked included: • Individual #82 was noted to require small bites and cues to slow down but was only listed as a low risk of choking. A concern that is been ongoing since the beginning of the DOJ SA reviews has been the idea by the centers that if supports are in place then the individual is at low risk. This interpretation increases the likelihood that individuals will not receive the services that are needed. An example is listed above regarding Individual #82. <u>Physical and Nutritional Management Team Referral Process</u> Two of two individuals from Sample O.1 (100%) were appropriately referred to the PNMT based on the criteria included in the Facility policy. In two of the two individual records reviewed from Sample O.1 (100%), when an individual experienced a change in status that would initiate a referral to the PNMT, there was evidence of referral to the PNMT within five working days of the ISPA meeting. A method in which the PNMT was made aware of changes in status was through participation by the PNMT lead and PNMT RN in the morning medical meeting. Information from this meeting was then brought to weekly PNMT meeting for further discussion and shared with the IDT as indicated if not already done so. There was a QA component to the PNMT in which data relevant to physical and nutritional supports on a systemic level 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. An example of using data to support changes were noted when the PNMT provided additional training as it related to PNMT consultation to ensure the IDT was	

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		aware of what did and did not constitute a consultation/referral. No individuals from Sample 0.1 received a feeding tube since the last review. . No individuals at RGSC received an emergency feeding tube placement since the last review. <u>PNMT Assessment</u> Two of two PNMT assessments/reviews (100%) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). Two of two PNMT assessments/reviews (100%) were completed in no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances (critical diagnostics requiring outside appointments, hospitalization, etc. with clearly stated rationale). Based on review of records for individuals who were referred to the PNMT, the comprehensiveness of the PNMT assessment components were as follows: • Two of two (100%) contained date of referral by the IDT. This information was contained within the ISPA. • Two of two (100%) contained a date of assessment. This information was contained within the PNMT assessment, or PNMT minutes. • One of two (50%) contained evidence of review and analysis of the individual's medical history. This information was contained as part of the PNMT RN Assessment and PNMT evaluation. • Two of two (100%) identified the individual's current risk rating(s), including the current rationale. This information was 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. • One of two (50%) contained assessment of current physical status. This information was contained within the PNMT minutes, the PNMT RN Assessment, and the PNM assessments. • One of two (50%) 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	

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		PNMT RN Assessment. • Two of two (100%) contained evaluation of skin integrity as indicated by the PNMT RN Assessment. • One of two (50%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene. • Two of two (0%) contained evaluation of current adaptive equipment. This information was contained within the Habilitation Assessment as well as part of the ISPA. • 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 two (0%) (both of whom were enterally nourished) identified residual thresholds. While the assessment did include mention of residuals greater than 100, the threshold identified was not individualized and did not consider the individuals' residual baseline. • A tableside oral motor/swallowing assessment was not provided as both individuals were enterally fed. • Two of two (100%) contained respiratory status. This was contained within the PNMT RN Assessment and discussed as part of the PNMT meeting • Two of two (100%) contained evidence of review/analysis of lab work. • Two of two (100%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects. • Two of two (100%) contained discussion as to whether existing supports were effective or appropriate. This information was contained within the PNMT RN Assessment as well as in the PNMT minutes and evaluation. • Two of two (100%) contained oral hygiene status. This information was contained within the Habilitation Assessment and there was evidence of review of this component as part of the ISPA minutes. • Two of two (100%) contained evidence of observation of the individual's supports at their home and day/work programs. • One of two (50%) contained evidence that the PNMT conducted hands-on assessment. While there was evidence of assessment, the assessment component did not comprehensively investigate root cause or develop a clear plan that was based upon provided assessments. • One of two (50%) identified the potential causes of the individual's physical and nutritional management problems. This information was contained within the	

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		PNMT RN Assessment, PNMT Assessment and PNMT minutes. • One of two (50%) 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. • Zero of two (0%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. Criteria for reassessment were provided as part of the PNMT evaluation but were lacking in detail, resulting in decreased ability to identify changes in status. For example, Individual #79 had an objective that stated the Individual will have improved motor coordination as evidenced by the use of restorator (a hand bike). No more information was provided regarding what the baseline was or what improvement will resemble functionally. • 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). • Zero of two (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT. While recommendations did exist, they were lacking in their ability to fully detect changes in status requiring follow up by the PNMT. For example, Individual #79 had a recommendation to re-assess if pulmonary infiltrates were noted in the right lung. Only looking at the right lung pneumonia episodes is narrowly focused and increases the likelihood of individuals who are experiencing pneumonia in lobes outside of the right lower not being provided with the appropriate assessments. • Two of two (100%) contained signatures with dates. In order to obtain substantial compliance, RGSC must improve their level of detail as it relates to the PNMT evaluation components listed above. <u>Review of Individual Cases</u> Concerns regarding individual #126 were as follows: • The Issue of degenerative spine disease was not addressed as part of the PNMT evaluation. Issues such as specific monitoring and reporting parameters for worsening myelopathy and pain, should have been addressed and reflected in the assessment.	

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		• The PNMT director commented that functional ability has shown improvement but lacking was any indication that routine functional assessments, that included range of motion measurements and assessment of deep tendon reflexes, were completed. • The Individual was recently evaluated by a pulmonologist for infiltrates noted on chest x-rays. Although the individual did not exhibit all the criteria required in Facility guidelines for diagnosis of pneumonia, the primary care provider (PCP) at the ISP planning meeting stated bronchoscopy findings indicated pneumonia. Please refer to Section L.1 for more information on discussion at the meeting and to Section L.4 for additional concerns specific to the Facility's policy for diagnosing pneumonia. • Additionally, a Schatzki Ring was documented as well as the Individual being post balloon dilation, per an EGD report. The condition is listed as a historic diagnosis, on the annual medical assessment with no evidence of routine or periodic swallowing assessments with esophagram occurring to determine status. Please see Section L.1 for additional information. Concerns were also noted for Individual #46. Individual #46 had shown significant decline in his ability to chew and swallow over the course of seven months (9/5/13 to 3/21/14). A list of points is provided below: • MBSS completed on 9/5/2013 recommended a regular diet texture with considerations to provide ½ portions to decrease rate of intake and the amount of food placed in the oral cavity. No aspiration was noted and only flash penetration was observed with thin liquids. • MBSS conducted on 3/21/14 recommended ground with pureed meats and Nectar Thick liquids. Aspiration was noted secondary to poor mastication. No follow up was done related to mastication. • ISPAs on 4/16/14, 4/1/14, 3/25/14, 3/18/14, 3/3/14 all showed evidence that his swallowing was discussed but the discussion focused primarily on supports and not why a decline was occurring. Even after the MBSS, no discussion as noted as to why there was a change in status was noted. • Per review and observation by the Monitoring Team, it was noted that Individual #46 had been having dental issues over the past few months and one of his teeth had broken off with possible root exposure; a nurse reported there was no sign of trauma. Dental pain and discomfort have been known to have significant impact on one's ability to properly masticate foods, which in this case was noted to be occurring during the last MBSS. No investigation or possible connection between the two was noted. • Please see Provisions L.1 and Q.2 for additional information.	

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		There was no documentation that dental clinicians, nurses, and the PNMT or other habilitation therapists assessed the possibility that Individual #46's oral condition and possible pain may have contributed to the poor mastication and the need for a modified diet, even following a swallow study that identified aspiration secondary to poor mastication. <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. Recommendations were not clearly linked or integrated into the IHCPs. For example, Individual #79's criteria for reassessment by the PNMT were not included as part of the IHCP. Plans resulting from PNMT recommendations for Sample O.2 included the following components: • In two of the two individuals' plans reviewed (100%), the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. • For one of the one individual for whom HOBE assessments were conducted (100%), the HOBE recommendations were integrated into individuals' plans. • In two of the two individuals' plans reviewed (100%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficac**y** 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 zero of two individuals' plans reviewed (100%), the plans included the specific clinical indicators of health status to be monitored. Clinical indicators of health status were not detailed enough or were missing, resulting in a decreased ability of staff to ensure that changes in health status were noted by staff. For example, Individual #126's IHCP did not include information regarding what staff should be monitoring to ensure safety and effectiveness of plan. • In two of two individuals' plans reviewed (100%), the plans defined triggers. • In two of two individuals' plans reviewed (100%), the frequency of monitoring was included in the plans. <u>PNMT Follow-up and Problem Resolution</u> With regard to plan implementation for Individuals in Sample O.2: • In one of two individuals' documentation reviewed (50%), supporting documentation was present to confirm implementation of individuals' action plan within 14 days, or sooner as needed, of the plan's finalization. Individual #79 was recommended to use a restorator on 2/18/14 but was not provided	

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		with the objective until 4/15/14. • In zero of the two individuals' plans reviewed (0%), documentation was provided to show action plan steps had been completed within established timeframes, or IPNs/monthly reports provided an explanation for any delays and a plan for completing the action steps. While Actions Steps existed, the person responsible, and timelines for completion were not consistently provided nor was evidence of the IDT re-convening to discuss results of action items provided. **<u>Individuals Discharged from the PNMT</u>** For individuals discharged by the PNMT in Sample O.2: ▪ Two of two individuals (100%) had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. ▪ Two of two individuals' (100%) discharge summary/action plan provided objective clinical data to justify the discharge. ▪ Zero of two individuals' ISPA meeting documentation (0%) provided evidence that any new recommendations were integrated into the IHCP. ▪ Zero of two individuals' ISPA documentation and/or action plan (0%) included criteria for referral back to the PNMT. 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 are integrated as part of the IHCP. Additionally, the PNMT should conduct look backs as part of the discharge process to ensure all action steps were not only implemented but were successful in meeting the intended need. Since the last compliance visit, RGSC's PNMT has developed key indicators that were designed to identify if services were being provided that met the needs of the individuals. Some the areas included in these key indicators were: • Number of individuals whose risk level increased or decreased • Percentage of mealtime monitoring that were compliant • Number of choking events caused by staff error. The collection of the data is a positive step forward in the PNMT providing more systemic assistance. Moving forward, the PNMT will need to use the data to drive services and training. This will be reviewed in subsequent visits as the process is still relatively new.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two	**<u>Identification of Individuals Requiring a PNMP</u>** For the ten individuals in Sample O.1 and O.2, ten of their annual ISPs (100%) noted that the appropriate disciplines were present to approve and integrate the PNMP in the ISP.	Substantial Compliance

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	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.	100% attendance by the OT, SLP and PT were noted at the meetings. Ten of 10 PNMPs (100%) from Samples O.1 and O.2 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 10 of 10 individuals (100%) were current within the last 12 months. • PNMPs for 10 of 10 individuals (100%) included a list of all high-risk levels and individual triggers as indicated. • In 10 of 10 most current PNMPs (100%), there were large and clear color photographs with instructions. • Ten of 10 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 two of two 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 10 of10 PNMPs (100%), positioning was adequately described per the individuals' assessments. • In 9 of 10 PNMPs (90%), the type of transfer was clearly described, or the individual was described as independent. • In 10 of 10 PNMPs (100%), bathing instructions were provided. • In 10 of 10 (100%) PNMPs, toileting-related instructions were provided, including check and change. • In 9 of 10 (90%) 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 10 of 10 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 10 of 10 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 eight of eight PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included.	

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		• In eight of eight PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. • In eight of eight 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 10 of 10 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. • In 10 of 10 PNMPs (100%), oral hygiene instructions were included, including general positioning and brushing instructions. • Ten of 10 PNMPs (100%) included information related to communication (how individual communicated, how staff should communicate with individual). A concern regarding Individual #126 PNMP was noted. This included: • The PNMP stated it was acceptable to lay the person flat for only a few minutes. Any time, and for any duration of time, that a person with documented risk factors for aspiration is in a flat position, the individual are at risk for aspiration. • The PNMP stated "staff to utilize mechanical lift (when necessary) for safety, and to minimize injury" In addition, there were no criteria developed to inform staff when to use, and not use a hydraulic lift; direct care staff must be specifically instructed when, and when not to apply a clinical support. <u>Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT</u> For individuals in Samples 0.1 and 0.2, for whom the IDT identified changes needed to be made to the PNMP, ISPA meeting documentation noted for ten of ten individuals (100%) that the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. For four of four individuals for whom the PNMP was revised, there was supporting documentation that four of four 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	<u>Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs</u> Three mealtime observations (2 lunches and 1 dinner) demonstrated that staff did not implement interventions and recommendations outlined in the PNMPs that were most likely to prevent swallowing difficulties and/or increased risk of aspiration. Per observations conducted by the Monitoring Team, 15 of 22 individuals' (68%) dining plans were implemented as written. While this still remains below acceptable limits, it should be noted that this represents an improvement of 28% since the previous	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>compliance visit. Examples of non-implementation included:
• Individual #21 was not consistently provided cues to slow down intake or sips to help clear oral cavity.
• Individual #24 was not observed being provided with cues to place her utensil on the table between bites in an attempt to allow time to chew and swallow. Failure to provide this strategy resulted in the individual taking multiple quick bites before chewing and eventually swallowing.
• Individual #91 was observed with both water glasses full when the PNMP called for only ½ of the cup to be filled at a time.

It should be noted that the atmosphere continued to improve and compliance on El Paisano remained at a much higher level than that of La Paloma. Most of the issues noted occurred on La Paloma.

Based on observations by the Monitoring Team:
• Three of three positioning plans for individuals' for Sample O.1 (100%) were implemented as written.
• One of one individual's transfer plan (100%) was implemented as written.

<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>6</td><td>100%</td></tr>
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		The accuracy of these responses improved compared to responses during the last compliance visit.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	RGSC had evidence of NEO training that comprehensively addressed the foundations of Physical and Nutritional Supports as well as annual refreshers geared towards maintaining competence. Per review of individual specific training, RGSC appeared to have a system in place that ensured staff was trained prior to working with individuals with increased risks. **NEO Orientation** The PNM related core competencies (i.e., foundational skills) were comprehensive. New employee orientation (NEO) included the following elements: • Lifting and Transfers; • Positioning (Alternate, wheelchair, and bathing/showering); • Adaptive Equipment; • PNMP orientation and implementation; • Safe Mealtime strategies; and • Basics of Dysphagia. The above components were included as part of the four following classes: • Lifting People • Physical and Nutritional Management • Dining Dos and Don'ts • Speech Training Since the previous compliance visit, all trainings related to PNM had been reviewed and revised to address more of the PNM related issues that are relevant to the population served. Forty-eight of 48 new employees (100%) successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs since the last onsite review. Three of three staff responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. **PNM Core Competencies for Current Staff** One hundred fifty one of 151 current staff that require training (100%) successfully	Noncompliance

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		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. <u>Annual Refresher Training</u> 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. <u>Individual-Specific Training</u> 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, #60 and #126 in Sample O.1 had received training on the latest revision to their PNMP. Two of three (67%) had evidence that staff were provided the needed training. Although requested, no evidence was provided that Individual #19 was provided with individual specific training as it related to the PNMP. Staff responsible for training other staff did successfully complete competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. The Facility did have a process to validate that staff responsible for training other staff are competent to assess other staff's competency. Training was provided by the Habilitation Therapists and therefore validation was not required.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	<u>Facility's System for Monitoring of Staff Competency with PNMPs</u> Monitoring tools included adequate indicators to determine whether or not "staff demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. 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.	Noncompliance

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		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 but had recently begun to include other staff (i.e., program specialist and RN Case Manager) to help with the process. 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. Inter-rater reliability checks were provided but there was no process that identified that they occurred at a certain frequency and who provided. Based on a review of the monitoring forms completed from 11/2013 to 3/2014, the PNMP monitoring process did not cover all areas that were likely to provoke swallowing difficulties or increase pnm risk, based on the following: • 45 % of the monitoring forms focused on oral intake (meals and snacks) • 2 % of the monitoring forms focused on bathing • 16 % of the monitoring forms focused on medication administration • 3 % of the monitoring forms focused on Oral Care. • 16 % of the monitoring forms focused on positioning • 15 % of the monitoring forms focused on Lifting/Transfers • 3 % of the monitoring forms focused on communication • 53 % occurred during first shift • 46 % occurred during second shift • 1 % occurred during third shift Based on review of monitoring completed between 11/1/13 to 3/31/2014, 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 that monitoring occurs across all shifts and settings that are likely to provoke swallowing difficulties. <u>Monitoring for Individuals in Samples</u> 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.	

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		For individuals in Sample O.2, PNM compliance monitoring over the past three months for two of two individuals (100%), the frequency of monitoring occurred as per the individuals' PNMT assessment and/or the individuals' plans/IHCPs. Frequency of monitoring primarily defaulted to the default monitoring schedule. It should be noted that since the previous visit, RGSC now had a PNMP Monitoring Process that contained a clear schedule that identified the frequency in which individuals at high, moderate and low risk would be monitored throughout the year.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	<u>IDT and PNMT Monitoring to Assess Individual's Progress and/or Effectiveness of the Plans</u> Two of 10 individuals' records in Samples O.1 and O.2 (20%) 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 10 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. QIDP 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. Newly implemented this visit was the PNMT reviewing high-risk individuals on a quarterly basis. The new process had the PNMT reviewing all high-risk individuals to determine status and identify overall effectiveness of the PNMP in mitigating PNM associated risks. While this new process was positive in that those at a higher risk would be reviewed more frequently, the process was still informal and not been formalized as part of policy or procedure. In order to achieve substantial compliance, RGSC must ensure all activities carried out by the PNMT are formalized and represented as part of the guidelines. Ten of 10 individuals' records (100%) 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 five Individuals in Sample O.1 and O.2 for the past three months. Triggers sheets were found to be correctly and consistently completed for two of five (40%) individuals.	Noncompliance

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		Three of five individuals' trigger sheets (60%) were reviewed at a minimum daily by the RN but not consistently every shift as directed. Five of five Individuals' Trigger sheets (100%) included individualized triggers as indicated. 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. • Case Manager's review of the trigger sheet was inconsistent. In order for the Facility to move towards substantial compliance: • 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. It should be noted that RGSC was aware of the issues and had recently implemented a corrective action plan that consisted of training as well as review by the IDT to determine who truly needed the level of protection that the Trigger sheet offers.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>Evaluation of Individuals who receive Enteral Nutrition</u> The Facility had a sustainable system to maintain and update a list of individuals who were enterally fed. Included as part of the list was the individual's home, name, type of feeding, date tube was placed, diet, and if the individual received any form of pleasure feeding. 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. 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.	Substantial Compliance

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		<u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u> Three of three individuals (100%) from Sample O3 who received enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. One individual (Individual #19) from Sample O.3 was identified as potentially benefitting from oral motor treatment as well as two others. These three individuals combine to represent Sample O.4. Three of three individuals who were identified as potentially benefitting from oral motor treatment or cleared to return to some form of oral intake (100%) had a comprehensive plan outlining the treatment or return to PO process. Three of three individual's plans to return to oral eating were based on the results of the IDT's discussion (100%) and were integrated in the IHCP, ISP, and/or an ISPA. Three of three individual's plans to return to oral eating n (100%) were implemented in a timely manner. Two of two staff responsible for implementation of these oral intake plans (100%) were competent to do so through competency-based training conducted by a licensed clinician with specialized training in PNM. The Speech Pathologist was responsible for treatment and therefore was competent in the ability to implement the plan. Three of the three individual's plans (100%) were monitored as outlined in the plan. Two of two individual's plans were modified by the IDT. For these individuals' plan (100%), the IDT met and interventions were reviewed and changed, as appropriate, in a timely manner.	

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 5/7/2014 2. RGSC Action Plan 5/7/2014 3. RGSC Policy 500-02 Physical and Nutritional Management Policy (revised 7/2013 and reviewed 3/2014) 4. RGSC Policy 400-19 Minimum Common Elements of Care (reviewed 3/2014) 5. RGSC Policy 400-02 At Risk Individuals (reviewed and revised 3/2014) 6. PNMT Monitoring Process (revised 12/2013) 7. Settlement Agreement Monitoring Tool for Section P 8. Key Indicators-Section P (not dated) 9. RGSC Policy 500-02 Occupational and Physical Therapy Services (rev: 8/2012) 10. RGSC Policy 500-02 Occupational and Physical Therapy Services (rev: draft: 5/2014) 11. Section P Presentation Book Record reviews: 12. Sample P.1: Individuals #5, #19, #33, #60, #77, #103, #132, and #145, 13. Sample P.2: Individuals #6, #72, 118, and #126 14. Lists of individuals: • Who cannot feed himself or herself and notation of any changes since the last review; • Who require positioning assistance associated with swallowing activities and notation of any changes since the last review; • Who have difficulty swallowing and notation of any changes since the last review; • At high and/or medium risk for aspiration pneumonia and choking; • With choking incidents since the last compliance review • Who had a feeding tube inserted since the last compliance review • Who were admitted to the hospital since the last compliance visit with admitting and discharge date and diagnosis • Who were diagnosed with pneumonia or a respiratory difficulty since the last compliance review (include date and type) • With falls in the last 12 months (date, location, type of injury)* • With chronic respiratory infections • With chronic dehydration • With fecal impaction • With pressure ulcers in the last 12 months (date, location and resolution) • With fractures in the last year (date, location of fracture, status) • Who were non-ambulatory or require assisted ambulation • With wheelchairs for primary mobility

	• With wheelchairs for transport • Who use Assistive Devices for ambulation (type of device) • With orthotic/braces 15. QA reports/matrix since the last compliance review 16. Habilitation Therapy Annual Assessment 17. Habilitation Therapy Update 18. Wheelchair/Adaptive Equipment Maintenance Log (last 6 months) 19. IRRF template 20. IHCP template 21. List of new employees since last compliance visit and their PNM related performance check offs 22. PNM Monitoring Tool template 23. Last three months of PNM monitoring data (including date, activity monitored, time of monitor, person conducting monitor) 24. For Individuals in Samples P.1 and P.2: • All ISPs in the last 12 months • All ISPAs in the last 12 months • All IRRFs in the last 12 months • All IRRF Action Plans in the last 12 months • IHCP/Action Plan • QIDP Monthly Reviews for the last 6 months • HOBE assessments • PNMT assessments and any other PNMT documentation other than IPNs in the last 12 months, if not already submitted • OT/PT assessments in the last 12 months • Six months IPNs • Trigger sheets completed in the last 6 months, including the current one • PNMPs in the last 12 months, including pictures • Dining Plans in the last 12 months, including pictures • Completed PNM-related monitoring sheets in the last three months • Evidence of effectiveness monitoring completed within the last six months • Direct intervention plan and supporting documentation for implementation of the plan (e.g., monthly progress notes) • Individual notebooks (PNM section) **People Interviewed:** 1. Jane Augustine PT Director of Habilitation Services 2. Victor Wilson OT 3. Betty Perez Rehab Tech II **Meeting Attended/Observations:** 1. PNMT meeting 5/20/14 2. Morning Medical 5/20/14 3. Mealtimes and Transitions (La Paloma, El Paisano)

	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 5/7/2014, and Action Plan dated 5/7/2014. 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 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 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). ▪ The Facility rated itself as not being in compliance with all provisions. This was consistent with the Monitoring Team's findings of noncompliance with Provisions P.1, P.2, P.3, and P.4 Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: RGSC showed general improvement as it relates to Provision P, although no areas of compliance were noted. The lack of root cause analysis as well as comparative analysis continued to pose concerns with regards to the overall assessment process. Improvement was noted with the monitoring process as it related to frequency of monitors completed, but it still lacked in its ability to monitor all areas that were likely to provoke swallowing difficulties. A system was recently developed that will ensure all individuals are provided with a level of monitoring that covers all areas in which their risk the issue; however, the process was still new and had not reached the level of implementation needed as evidenced by there being little evidence that staff or the individual were 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 lacked evidence of consistent comparative

	analysis and measurements to assist in determining the efficacy of the provided interventions. **Provision P.2:** This provision was determined to be not in compliance. 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. **Provision P.3:** This provision was determined to not be in compliance. The Facility was not able to provide information regarding whether staff had been trained on individuals' plans of care. There was evidence of NEO training and annual refreshers but inconsistency regarding individualized training. **Provision P.4.** This provision was determined to be not in compliance. While the monitoring system showed signs of improvement, all areas and times in which swallowing problems were likely to be provoked were not consistently provided. Another concern was that the Facility did not consistently use the data to pinpoint areas of concern on a systemic basis; therefore, the need for training or development of an action plan would be difficult to determine.

#	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. <u>Timeliness of Assessments</u> 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 assessments for newly admitted individuals (100%) were posted a minimum of five working days before the admission ISP meeting.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Four of four newly admitted 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. Seven of eight individuals' OT/PT assessments in sample P.1 (88%) were dated as having been completed at least 10 working days prior to the annual ISP. Eight of Eight assessments or updates in Sample P.1 (100%) were current within 12 months for individuals who are provided PNM supports and services. <u>OT/PT Assessment</u> Based on review of the sample of assessments, the comprehensiveness of the OT/PT assessments for samples P.1 were as follows: • Eight of eight individuals' OT/PT assessments (100%) were signed and dated by the clinician upon completion of the written report. • Seven of eight assessments (88%) included diagnoses and relevance to functional status. • Eight of eight 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. • Seven of eight assessments (88%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous years or assessments. • Two of eight individuals' OT/PT assessments (25%) offered a comparative analysis of current functional motor skills and ADLS with previous assessments. This was an area that was noted to decline since the last compliance visit. An example is provided below with regards to individual #85. Measurement as it relates to individuals with potentially worsening conditions was not consistently provided. This was an area noted in previous reviews and has shown little improvement and recent decline. • Seven of eight assessments (88%) included medical history and relevance to functional status. • Eight of eight assessments (100%) addressed health status over the last year. • Eight of eight assessments (100%) listed medications and potential side effects relevant to functional status. • Eight of eight assessments (100%) included documentation of how the individual's risk levels impact their performance of functional skills.	

#	Provision	Assessment of Status	Compliance
		• Eight of eight assessments (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). • Eight of eight assessments (100%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. • Eight of eight assessments (100%) included discussion of the expansion of the individual's current abilities. • Four of 8 assessments (50%) included discussion of the individual's potential to develop new functional skills. • Five of eight assessments (63%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. • Eight of eight 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. • Eight of eight assessments (0%) included a monitoring schedule. The monitoring schedule primarily listed was the default schedule that is based upon risk. The monitoring portion of the assessments often stated that the default schedule would be utilized. There was evidence in the form of a guideline or procedure that clearly identified what this frequency was. • Eight of eight assessments (100%) included a re-assessment schedule. The reassessment schedule at RGSC was an updated every year if receiving direct or indirect services. • Eight of eight individuals' OT/PT assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. • Eight of eight 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 eight (100%) included evidence that communication and or collaboration was present in the OT/PT assessments as evidenced by dated signature. • Eight of eight assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This information was primarily contained within the PNMP. 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. Additionally, comparative analysis from year to year had shown improvement in the past but had	

#	Provision	Assessment of Status	Compliance
		declined since the new assessment format was implemented at RGSC; improvement is needed. Also noted was lack of root cause analysis of new issues or revisiting of measurements as it relates to range of motion, flexion, and/or motor skills. These are addressed in a much more comprehensive manner every three years when the full assessment is provided. RGSC may want to consider providing full assessments for certain individuals who have complex medical needs. An example of an individual who would benefit from detailed annual assessments including measurements as it relates to range of motion would be someone with a diagnosis of Parkinson's, Multiple Sclerosis and/or Cerebral Palsy. There continued to be a lack of detailed assessment in response to potentially progressive diseases/disorders. For individuals with potentially worsening conditions, the early identification of decline (even prior to functional decline) is needed and warranted so that plans of care may be developed in a timely manner. An additional concern noted was that individuals were observed using exercise equipment without being provided proper assessment to determine appropriate settings and technique to ensure safety. Performing exercise on a piece of equipment using improper settings increases the likelihood of muscular injury during use. Concerns were also noted regarding the assessment of Individual #126: These included: • Given the diagnosis of significant degenerative spine disease, myelopathy, recurrent emesis, and risks associated with GERD, the Monitoring Team was concerned that the assessment did not clearly identify if a two-person lift, or if the use of a hydraulic lift was in the best interest for the Individual. • There was no indication that a medical evaluation was completed to ensure that the Individual's musculoskeletal system could safely support pivot transfers, and ambulation, which was being provided by staff. • The PNMP stated "staff to utilize mechanical lift (when necessary) for safety, and to minimize injury". As noted above, the Monitoring Team is concerned that there were no assessments as to the safest and most appropriate means for transfer. In addition, there were no criteria developed to inform staff when to use, and not use, a hydraulic lift; direct care staff must be specifically instructed when, and when not, to apply a clinical support. • Given the known significant risks for aspiration, the Monitoring Team is very concerned that the recommendation for positioning stated "during personal care, head of bed may be flat for a few minutes ONLY." Any time, and for any duration of time, that a person with documented risk factors for aspiration is in a flat position, the individual is at risk for aspiration. These concerns were shared with RGSC and it should be noted that plans were put in	

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		place to begin to address the identified concerns. The Monitoring Team's review for Section L.1, of this report, noted the OT/PT Comprehensive Assessment Evaluation, updated 9/23/2013 for Individual #85, did not include range of motion measurements for this Individual, who has a diagnosis of cerebral palsy, and spasticity. Also, the assessment included a measurable objective for this Individual to have less than four falls within the year. The Facility's expectation of less than four falls is not clinically appropriate, and the expectation should be to target zero falls for the year. There has been no evidence of reassessment in which new targets as well as new measurements may be provided. The concern regarding not setting clinically appropriate goals was noted to be pervasive as Individual #140 also had a goal related to falls that focused on the reduction rather than elimination of the falls. Other concerns noted included: The Monitoring Team noted the following for the documents reviewed for the first five individuals on the list of all individuals with a diagnosis of cerebral palsy (Individuals #115, #85, #143, 19 and #61): • The PT/OT assessment indicated specific measurements when assessing spasticity in zero out of five examples (0%). • There was evidence that specific PT/OT treatments were provided to help minimize progression of contractures in zero out of five examples (0%).	
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	<u>OT/PT Interventions</u> For individuals receiving OT/PT supports and services, 10 of 12 plans for Samples P.1 and P.2 (83%) were developed within 30 days of the date of the assessment/update, or sooner as indicated by need. A concern noted was that individual in need of direct treatment were not consistently provided with such treatment. For example: • Individual #145 has had numerous falls when transitioning from grass to concrete but no recommendations for treatment to improve transitional awareness was provided. • Individual #5 has had issues with falls and is listed as being at "high risk". Upon assessment, the recommendation was for the individual to not pick up items from floor. No treatment was provided to improve balance or awareness. For six of eight individuals in Sample P.1 (75%), the ISP/ISPAs addressed each of the recommendations outlined in the current OT/PT assessment.	Noncompliance

#	Provision	Assessment of Status	Compliance
	outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	<u>Direct OT/PT Interventions</u> <u>Direct OT/PT Interventions were inconsistent in their documentation as evidenced by:</u> • Three of 4 individuals' direct intervention plans (75%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. • For 4 of 4 individuals' records (100%) reviewed, the current OT/PT assessment identified the need for direct intervention with rationale. • For zero of four individuals records reviewed (0%), there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. • For zero of four individuals' records (0%) whose therapies had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. 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. <u>Indirect OT/PT Programs</u> The implementation of these plans is also discussed under Section O4 for PNMPs and in Section S for skill acquisition plans. <u>Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP</u> An OT or PT attended the ISP or ISPA meeting. Twelve of 12 ISP annual meetings for Samples P.1 and P.2 (100%) had a member from either OT or PT present to represent the disciplines. Eight of eight ISPs or ISPAs in Sample P.1 (100%) clearly integrated the OT/PT interventions. The ISP or ISPA did consistently describe the supports based on the rationale provided in the therapy assessment. This information was contained primarily in the form of a review of the PNMP. In eight of eight of the ISPs or ISPAs reviewed (100%), skill acquisition programs or opportunities for skill acquisition that had been recommended in the OT/PT assessment were present. For eight of eight individuals from Sample P.1 (100%), the ISP/ISPAs contained measurable objectives; however, there were not clear identified functional outcomes included as part of the ISP or ISPA. A comprehensive progress note was completed on at least a monthly basis. Zero of four	

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		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. For individuals with PNMPs or SAPs focused on indirect services, for 0 of 8 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 QIDP did not include: • Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); • A description of the benefit of the program; • Identification of the consistency of implementation; and • Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. The monthly QIDP report did not consistently 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. Additionally, per review of the data sheets, missing or inaccurate data was a pervasive issue and noted with all individuals in Sample P.1. Examples consisted of either data not being recorded or data being recorded when the individual was not present. This was a concern expressed by the Director of Habilitation Services as well as the other Clinicians.	
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	The requirements for this section were discussed in detail with regard to Section O.5. Noncompliance was found with regards to Section O.5 This provision was found not to be in substantial compliance. RGSC had evidence of NEO training that comprehensively addressed the foundations of Physical and Nutritional Supports as well as annual refreshers geared towards maintaining	Noncompliance

#	Provision	Assessment of Status	Compliance
	competency-based training in implementing such plans.	competence, but was only able to provide evidence of individualized training for two out of three (67%) Individuals.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	<u>Monitoring System</u> The Facility did not implement a system for the adequate monitoring of PNMPs. • See Provision O.6 The Facility did not have a comprehensive OT/PT policy. The policy included the following elements: • Description of the role and responsibilities of OT/PT; • Defines the monitoring process for the status of individuals with identified occupational and physical therapy needs; • Defines how individuals' OT/PT needs will be identified and reviewed; and • Sets forth documentation expectations for individuals receiving direct services Missing from policies/procedures reviewed were elements that: • Define the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; • Include re-evaluation of monitors on an annual basis by therapists and/or assistants; • Describe referral process and entrance criteria; • 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; It should be noted that RGSC was still in the process of revising their OT/PT policy (this process has been in excess of 6 months) but this had not been completed as of this date. This policy will be reviewed at subsequent visits. It appeared that the revised policy addressed many of the concerns highlighted above as missing from the policy. For eight of eight 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		equipment were included as part of the risk based PNMP monitoring. For 34 of 34 individuals for whom adaptive equipment was noted to be in disrepair or needing replacement (100%), equipment was repaired or replaced within 30 days unless justification was provided, or unless the issue impacted the individual's health or safety, then action was taken within 48 hours.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Self-Assessment (5/7/2014) 2. RGSC Action Plan (5/7/2014) 3. Presentation Book, November 2013. 4. RGSC Standard Operating Procedure, ICF-IID 400 16; Premedication for Medical and Dental Procedures, dated October 2013. 5. RGSC Standard Operating Procedure ICF-IID 400 12: Dental Services, Revised March 2014. 6. Copy of last six months and next six months appointment schedule for annual dental examinations. 7. 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. 8. Spreadsheet document that indicated appointment dates for dental services for the past six months. 9. Written statement informing the Monitoring Team that it did not maintain a list of future dental appointments. 10. Dental records for Individuals #31, #66, #45, #114, and #65. 11. Alpha list of all individuals who the Facility has identified as not being current with dental radiography. 12. Alpha list of all individuals who have <u>not</u> had bitewing dental x-rays (or alternative to bitewings) within the past 24 months. 13. Dental record and IPNs associated with dental emergencies for Individual #12. 14. Active clinical record for Individual #46. 15. ISPs for Individuals #126, #79, and #19 16. List of individuals who require pre-treatment oral sedation for dental services on a regular basis 17. Dentist's post-procedural note for Individuals #12 and #15. 18. List of individuals who were identified as requiring a program to help minimize the need for sedation 19. Data tracking sheets for dental rehearsals **People Interviewed:** 1. Mario Menchaca, Dental Hygienist 2. Lorraine Hinrichs, ICF-IID Program Director **Meeting Attended/Observations:** 1. None
	Facility Self-Assessment: Following its review of the self-assessment for Section Q, the Monitoring Team noted that the Facility: • Did not use monitoring/audit tools that relied on sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement. The Self-Assessment did not give information other than that the audits met timeframes, sample size requirements, and if compliance was achieved. • The monitoring tools did not include sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes..

	• The Self-Assessment did identify the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall. The sample sizes were adequate to consider them representative samples. The number or percent of sample size of individuals/records as compared to the overall population was included in the Self-Assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was provided, mostly only overall percentage of compliance without information on what did and didn't comply. • The Monitoring Team could not determine that the Facility's monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring. • It was unknown to the Monitoring Team if sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools. The Facility's self-assessment stated that the Facility was not in compliance with Sections Q.1 and Q.2, and the Monitoring Team concurs with the self-assessment of noncompliance.
	Summary of Monitor's Assessment: The Monitoring Team concurs with the Facility's self-assessment of noncompliance for Section Q. The Monitoring Team noted no significant improvement with moving towards substantial compliance. The Facility must 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 Facility must also ensure that dental emergencies are triaged more readily, and are closely monitored through full resolution of the oral health condition. Also, the Facility must review its process to ensure all individuals who require pre-treatment sedation, and anesthesia, are safely provided necessary treatments. The following are some additional comments, specific for each Section of this Provision: **Provision Q.1:** Enhancements with the provision of dental services had not been achieved during the review period. The Facility did not have a systematic mechanism in place to ensure the appropriate provision of emergency and routine dental services or processes to ensure appropriate oral hygiene and suction toothbrushing. It should be noted that the provision of restorative care was not assessed at this compliance review, but will be assessed at future reviews. Because of the continued deficiencies noted by the Monitoring Team, the Facility remains noncompliant with Section Q.1, of the Settlement Agreement. **Provision 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 to reduce the need for dental pre-treatment sedation, such as one 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 assesses 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.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	To assess 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. In addition, the Facility had recently hired a full-time dental hygienist who will oversee dental services at the Facility. <u>Annual Dental Examinations and Routine Dental Hygiene</u> To assess the provision of routine dental services, the Monitoring Team requested the following information: 1. Copy of last six months and next six months appointment schedule for annual dental examinations 2. 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: a. Name b. Date of previous years annual dental examination c. Scheduled date for most recent dental examination 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 8 individuals, out of the current census at the Facility of 66 individuals, had not completed their annual dental	Noncompliance

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		examination (12%). The Facility provided documentation stating that five out of the eight (63%) cases were rescheduled because of challenging behavioral issues; one out of eight (13%) was rescheduled by the dental office because the dentist was out of town; and two out of eight (25%) were rescheduled because of operational issues. The Facility provided a list of dates indicating when the individuals who are not current with their annual dental examinations will be provided their annual dental examination. All eight individuals are scheduled to follow-up with the dentist for their annual dental examination by June 2014. The Facility provided a spreadsheet document that indicated appointment dates for dental services for the past six months. The spreadsheet was not specific for annual dental exams, as requested, but inclusive of all dental services. Furthermore, the Facility provided a written statement informing the Monitoring Team that it did not maintain a list of future dental appointments. The Facility did not provide a specific list of individuals who were provided dental hygiene during the past six months, and included the following written statement: "All individuals have had dental hygiene during this reporting period. The only individuals who have not are all edentulous and only get seen once a year". The Monitoring Team had requested the list to evaluate the frequency of dental hygiene treatments, and the type of dental hygiene visits but did not receive it. The Monitoring Team requested the most recent annual dental summary, and all available dental records for the first two and last three individuals on the current name key (Individuals #31, #66, #45, #114, #65): • The annual dental summary was not provided for Individual #45. • For two out of five examples (40%), the dentist indicated behavioral challenges limited treatment and examination, and requested either pre-treatment sedation, or anesthesia. • Individual #66 was referred for further treatment and evaluation under general anesthesia on 2/10/2014; however, upon review of the dental schedule that was provided, this service was not completed or scheduled to be completed. • Individual #65 was noted to require "multiple extractions" on 12/16/2014, and again on 3/10/2014. The dental schedule indicates that the dentist saw the Individual on 3/13/2014, but there were no dental records provided; therefore, the Monitoring Team was unable to determine if the necessary extractions were completed. • Individuals #31, and #45 were scheduled for three month recalls but were not seen by a dental professional during that time frame. The appointment for	

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		Individual #31 was delayed one month, and Individual #45 two months.
		
		During a meeting with the Facility's current dental hygienist, the Monitoring Team was informed that "many" individuals would benefit by pre-treatment sedation, or anesthesia; however, further details as to exact numbers of Individuals, and the names of specific Individuals who would benefit from such services were not available.
		
		Summary.
		Information indicated 88% of individuals served by the Facility were seen by a dentist for their annual dental examination within 365 days from the previous annual dental examination. For individuals who had not received a timely annual dental examination, the Facility had already scheduled all eight cases to be evaluated by the dentist by June 2014. Because a specific list of dental hygiene treatments was not provided, and because the five examples reviewed did not include specific documentation indicating what specific dental hygiene was provided, the Monitoring Team could not assess provision of dental hygiene at the Facility. The Facility must identify all individuals who would benefit by either pre-treatment sedation and sedation, and ensure that such services are provided as necessary. The Facility must also enhance its ability to track and trend all dental appointments, and ensure that follow-up dental appointments are scheduled in advance.
		
		<u>Dental Radiography</u>
		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 <u>not</u> 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:
		  • Reason why dental x-rays are not current
		  • Copy of IDT minutes and/or ISP minutes that comment on delinquent dental x-rays, and specific plan to address incomplete dental x-rays
		
		Documentation provided, and the findings from that documentation, was as follows:
		• The documents provided for review, regarding dental imaging studies, were confusing. For example, the document listed six individuals as not being current with dental radiography, which was followed by an additional, and different, list of ten individuals who were not current with dental radiography. To further	

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		complicate the review, the Facility provided a statement that stated "all individuals currently at the Facility have had bitewing dental x-rays within the past 24 months (or alternative to bitewing x-rays), and there was no supplemental information, as requested, for the Monitoring Team to assess completion of dental radiography. For these reasons, the Monitoring Team was unable to assess the Facilities provision of clinically appropriate dental radiography. Summary: Because conflicting information was provided, and because specific documents requested to assess the provision of dental radiography were not provided for review, the Monitoring Team could not assess the Facility's provision of dental radiography. <u>Management of dental emergencies</u> The Facility provided documentation for one individual (Individual #12) who experienced a dental emergency during the reporting period. Individual #12: • A nursing IPN was completed at 0801 on 2/13/2014 indicating swelling to right cheek, and that the medical provider would evaluate the Individual; however, there was no follow-up IPN by the medical provider submitted for review, and there was no evidence indicating orders for pain medication, antibiotics, or for monitoring and reporting parameters for this condition. • The Individual was triaged to the local hospital on 2/14/2013 for further evaluation and the dentist who evaluated the Individual was unable to assess oral health care issues and recommended an exam under general anesthesia to be completed as soon as possible. • On 2/14/2014, following the emergency room visit, the Facility's medical provider prescribed antibiotics, and the Individual was scheduled for follow-up under general anesthesia on 2/27/2014. • The dentist documented a post-surgical note on 2/27/2014, indicating that swelling was not noted, and there was no dental cause noted that could result in swelling; however, a non-restorable tooth was extracted (tooth #14). • There was no follow-up documentation by the dentist or medical provider submitted for review. • It should be noted that the same Individual experienced the same type of dental emergency at the time of the last compliance review, and at that time and the issue was delineated on the last compliance report, as follows: o A nursing IPN dated 8/2/2013 documented that the Individual demonstrated pain, and swelling of the left cheek, and the Individual	

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		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. • There was no evidence provided that supported a medical evaluation being completed to determine the cause of recurrent swelling. Individual #46 • During the medical morning meeting observed by the Monitoring Team on 5/21/2014, it was reported that the Individual sustained a broken tooth on the prior day. An injury report was completed on 5/20/2014, stating that the Individual "walked into the nurses station stating a tooth had fallen out of his mouth while walking to nurses station". A nursing assessment was completed that stated "no injury noted, no bleed or swelling noted to site, no treatment required". The Individual was seen by the medical provider on the same day, who documented that there was "no evidence of trauma" and that the Individual had "lost a tooth from his lower gum and without bleeding. Some cavities. I think he has chronic periodontal disease"; and for the clinical plan it was documented "I think (the Individual) is going to see a dentist for evaluation for periodontal disease and of the tooth he lost. Otherwise, cardiopulmonary condition is present when I see (the Individual)". The Monitoring Team reviewed the dental schedule and noted that the Individual was scheduled to see a dentist for the lost tooth, on 5/28/2014, eight days following the loss of the tooth. There was no description of the tooth, or determination if the entire tooth had fallen out or if the tooth had fractured and the root remained exposed, by either the medical provider or the nurse. Furthermore, there was no documentation of additional supports and services provided to assist the Individual prior to seeing a dentist. For example, there was no evidence that increased monitoring for pain or discomfort would be assessed, and no increased monitoring during meals and drinking fluids. The Monitoring Team observed the Individual at his living area on 5/22/2014, and when the Monitoring Team asked the Individual how he was doing, he immediately	

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		indicated that his mouth hurt. The Individual explained to the Monitoring Team that the pain was intermittent, was "sharp", and would wake the Individual up at night. The Monitoring Team asked the direct care staff if they were instructed to enhance monitoring for pain and challenges when eating; the staff stated "no". Furthermore, upon review of the clinical record, on 3/21/2014 a modified barium swallow study was completed and the Individual was noted to have had aspiration of food secondary to poor mastication, and no further work-up was documented; ultimately, the Individual was started on modified diet, that the Individual told the Monitoring Team that he did not like. There was no documentation that dental clinicians, nurses, and the PNMT or other habilitation therapists assessed the possibility that the individual's oral condition and possible pain may have contributed to the poor mastication and the need for a modified diet, even though swallow study that identified aspiration secondary to poor mastication. It should be noted that the Monitoring Team reported the Individual's report of continued pain and the prolonged wait time before the dental appointment to the Facility's ICF/IID Program Director. Summary. The Monitoring Team is concerned that dental emergencies were not efficaciously managed by the Facility. Initial medical assessment and close medical follow-up were not evident, and triaging dental emergencies was delayed. <u>Oral Health Care at the Living Area</u> 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 or 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, addendums to the ISPs, or any other document indicating the sample individuals' oral health care plans and status of oral health care.	

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		The dental hygienist informed the Monitoring Team that the Facility developed a process to assess the provision of oral health care at the living area, that specifically will assess staff assistance with providing oral health care, as well as assessing the Individuals' oral health care. This process had not been substantially implemented at the time of this compliance review. 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 must ensure that staff are routinely assessed on their implementing oral hygiene assistance as needed by individuals. <u>Suction Toothbrushing</u> To assess the Facility's process for providing suction toothbrushing, the Monitoring Team requested the following documentation: • Suction toothbrush policy • 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 please provide: 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 did not provide a copy of policy for suction toothbrushing in the documents received for Section Q.1, and therefore the Monitoring Team was unable to determine the Facility process for initial and ongoing identification of individuals for suction toothbrushing, assessment of the efficacy and safety of suction toothbrushing, and process to assess administration of suction toothbrushing. The dental hygienist informed the Monitoring Team that on-going assessments for suction toothbrushing was not provided after the initial assessment, and that a system to regularly assess the efficacy of suction toothbrushing had recently been developed, but not substantially implemented. The Facility documented three individuals being provided suction toothbrushing (individuals #126, #79, and #19):	

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		• Individual #126: the most recent ISP indicated that suction tooth brushing was provided following all meals. The IRRF did not document risks associated with suction tooth brushing under the dental section of the IRRF, and did not indicate suction tooth brushing as related to a risk for aspiration. • Individual #79: The most recent ISP indicated that suction tooth brushing was to be provided by nursing staff. The IRRF did not list risks associated with suction tooth brushing, and did not list suction tooth brushing as a risk for aspiration. Under dental supports, the IRFF did indicate that suction tooth brushing was provided. • Individual #19: The ISP did document that suction tooth brushing was provided for oral care by the nurse. The IRRF did not list risks associated with suction tooth brushing, and did not list suction tooth brushing as a risk for aspiration. Under dental supports, the IRFF did indicate that suction tooth brushing was provided. Summary: The Facility ensured that the need for suction tooth brushing was documented on the most recent ISP and IRRF. Because the Facility did not have a standardized mechanism to ensure the on-going need for suction toothbrushing, and did not implement its process to assess the efficacy and safety of suction toothbrushing, and administration of suction toothbrushing; and because risks associated with suction tooth brushing, such as aspiration were not documented on the IRRF, the Monitoring Team determined that the Facility's suction toothbrushing program continues to require further enhancement. Conclusion: The Monitoring Team is concerned that enhancements with the provision of dental services has not been achieved during the review period. The Facility must continue to develop mechanisms to enhance the assessment of oral health care and suction toothbrushing; ensure timely follow-up for dental recall; better assess individuals for pre-treatment and general anesthesia; ensure prompt and efficacious management of dental emergencies, that includes close follow-up by the medical provider, and assessment by the IDT. It should be noted that the provision of restorative care was not assessed at this compliance review but this will be assessed at future reviews. Because of the continued deficiencies noted by the Monitoring Team, the Facility remains noncompliant with Section Q.1 of the Settlement Agreement.	
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>Pre-treatment oral sedation</u> The Facility provided 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 14 individuals require pre-treatment oral sedation for oral healthcare treatment; however, the Facility indicated that only two individuals were provided pre-treatment oral sedation for dental services during the review period. Given that, per a statement by the dental hygienist and noted in follow-up requests on annual dental summaries, most individuals are to be provided dental hygiene every three months, the Monitoring Team expected to see all 14 individuals on the list of individuals who were provided pre-treatment oral sedation. As with the previous compliance report, 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 providers' integrated progress notes (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. As delineated in Section Q.1 of this report, the Monitoring Team is concerned that Individuals who need pre-treatment oral sedation, as well as general anesthesia, are not being provided such treatment as clinically indicated. 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. The Facility must ensure that Individuals who require pre-treatment oral sedation, and who can safely be administered pre-treatment oral sedation, are provided such treatment to help ensure adequate oral health and dental services. The Facility must ensure that a standardized medical or nursing assessment is completed prior to and following the administration of a pre-treatment oral sedation. <u>Dental Anesthesia</u> The dental hygienist informed the Monitoring Team that its dental professionals do not	

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		use TIVA as a form of anesthesia, but instead perform all necessary evaluations and treatments under general, intubation, anesthesia at the local hospital. The Facility indicated that a total of 19 individuals require anesthesia to complete dental services; however, during the reporting period, the Facility only provided anesthesia to two individuals, and in the last 24 months, only 20 anesthesia treatments were provided. Also, per discussion with the dental hygienist, who accompanies individuals to the community dentist, and is same dental hygienist who performs dental hygiene, it was made aware to the Monitoring Team that abnormal movements and challenging behaviors were limiting factors when attempting to provide comprehensive dental services. The Monitoring Team had requested all anesthesia related monitoring by the Facility for individuals who were provided general anesthesia during this reporting period; such documentation would include nursing IPNs to assess the individuals prior to transferring the Individuals for anesthesia, and continued post anesthesia monitoring at the living area. The only documents provided were for the two individuals who were provided general anesthesia (Individuals #12 and #15) and only included copies of the dentist's post procedural note, and there was no evidence documenting that a formal nursing assessment had been completed prior to transferring, or for continued post anesthesia monitoring once back at the Facility. Summary: The Monitoring Team is concerned that methods to promote regular dental services, such as pre-treatment oral sedation, TIVA, and other forms of general anesthesia are not provided as clinically indicated, perhaps even for individuals for whom such methods have been planned. Furthermore, there was no evidence to support effective pre- and post-anesthesia assessment and monitoring by the Facility. <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 12: Dental Services, Revised March 2014. 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 dental hygienist informed the Monitoring Team that the Facility had yet to fully implement its dental rehearsal program, but has increased the number of	

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		opportunities offered to individuals who require such programs. Further discussion indicated that the program specifically focused on the Individuals becoming used to a specific staff person, who would be responsible to assist the individual at each dental visit; hence, there was no change in this format since the last review period. The Monitoring Team shared concern that such a program could evoke dependency on a single staff member, and in turn could result in reemergence of challenging behavior exacerbation in the event that a particular staff person was no longer available to support the individual. The Facility provided a list indicating the names of 20 individuals who were identified as requiring a program to help minimize the need for sedation. Outcome data to assess progress of the program to help minimize the use of sedation was provided for only 10 of the 20 individuals (50%). Review of the ten individuals' data tracking sheets for dental rehearsals indicated that the frequency of program implementation was extremely low: • Individual #31 was provided 11 dental rehearsals during the past six months. • Individual #55 was provided 9 dental rehearsals during the past six months. • Individual #72 was provided 8 dental rehearsals during the past six months. • Individual #51 was provided 12 dental rehearsals during the past six months. • Individual #48 was provided 7 dental rehearsals during the past six months. • Individual #45 was provided 5 dental rehearsals during the past six months. • Individual #139 was provided 16 dental rehearsals during the past six months. • Individual #36 was provided 12 dental rehearsals during the past six months. • Individual #91 was provided 8 dental rehearsals during the past six months. • Individual #66 was provided 8 dental rehearsal during the past six months. The total number of dental rehearsal opportunities offered to individuals during the last six months was 96, which would be an average of four opportunities provided to individuals each week and an average of 9.6 opportunities per individual over six months. Forty-four opportunities (46%) were considered successful opportunities, that is, times when the individuals actually participated with the program. Although this is a slight increase from previous compliance reports, the Facility must continue to provide additional opportunities for dental rehearsals. There was no data provided to indicate the effectiveness of each program. Summary: The Facility has yet to substantially implement a clinically effective mechanism to help minimize the use of sedation for dental treatments. The Facility must substantially	

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		implement its program to help 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.
		
		<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:
		• 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 Facility has developed, albeit not substantially implemented a dental QA process to assess suction toothbrushing and oral hygiene; however, these two indicators had just recently been developed, and could not be assessed for efficacy.
		
		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>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 efforts documented to help mitigate future missed appointments.
		• Total number of missed dental appointments during that past six months
		• Total number scheduled
		• Number of missed appointments because of illness of the individual	

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		• 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 reasons for missed appointments that occurred during the reporting period: • The Facility documented that a total of 108 dental appointments were scheduled for dental appointments, during the reporting period, with 29 missed appointments; hence 79 out of 108 appointments (73%) occurred as scheduled. • Zero out of 108 scheduled appointments (0%) were missed secondary to staffing issues at the living area. • Zero out of 108 (0%) missed appointments were secondary to transportation related issues. • Four out of 108 (4%) missed appointments were due to dental clinic issues, such as staffing issues at the dental clinic. • Zero out of 108 (0%) missed appointments were due to not obtaining consent for treatment. • 25 out of 108 (23%) missed appointments were due to other reasons. The dental hygienist informed the Monitoring Team that the Facility had still not implemented the DADS dental database system to schedule and track dental appointments and services, and continued to use a spreadsheet for scheduling purposes. The Monitoring Team reviewed the schedule spreadsheet, and noted that it did not enable efficient or effective review, with regard to tracking of specific types of dental services that were provided in the past, and pending appointments. For example, upon reviewing the dental spreadsheet for the past six months, the Monitoring Team was unable to readily determine if all annual dental examinations and dental hygiene appointments were completed as scheduled, as the spreadsheet could not break appointments down by category. In addition, when observing the functionality of the scheduling system, the Monitoring Team noted significant challenges. For example, dental appointments were not routinely scheduled for follow-up appointments more	

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		than one month in advance, so there was no efficient means to determine future appointments of each Individual's annual dental exam, dental hygiene appointments, and scheduled restorative treatments. The Monitoring Team had asked to see specific future appointments for several individuals, including the appointment for Individual #46, who required an emergency dental evaluation; the appointments were not on the schedule spreadsheet, so staff who were familiar with scheduling appointments had to be tracked down and asked when an appointment was to be made. The spreadsheet did not readily enable staff to search for individual appointments, so staff had to review each and every month on the spreadsheet to verify when an appointment was scheduled for. Summary: The Facility did not maintain an effective, efficient scheduling system that enables tracking and trending of dental appointments. The Facility did not have an internal process to assess appointment failures, and to develop strategies to help mitigate appointment failures. <u>Conclusion:</u> The Monitoring Team concurs with the Facility's self assessment of noncompliance with Section Q.2, and as per the last compliance report, the Monitoring Team 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 pre-treatment oral sedation, general anesthesia, and other forms of anesthesia. It is essential that the Facility develop a dental QA process that assesses the quality and efficacy of dental services, and that regularly assesses potential adverse outcomes, such as pneumonia, behavioral exacerbation, and injuries 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 5/7/14 2. RGSC Action Plan 5/7/14 3. RGSC Policy- 500-03 Communication Services (rev October 2013) 4. Facility Section R Presentation Book Record Reviews of Individuals: 5. Sample R.1: Individuals #55, #62, #74, #94, #97, #98, and #103 6. Sample R.2: Individuals #29, #81, and #97 7. Sample R.3: Individuals #48 and #60 8. Sample R.4: Individuals #55, #74, #84, #94, and #97 9. List of current SLPs, caseloads and ratios 10. Copies of each SLP's current license and ASHA certification 11. Continuing education and training completed by the SLPs in the past 12 months 12. Facility list of new admissions since the last review 13. Tracking log of SLP assessments completed since the last review 14. Facility list of individuals with severe language deficits 15. Facility list of individuals with PBSPs and replacement behaviors related to communication 16. PBSP minutes and attendance rosters for the past six months 17. Facility list of individuals with Alternative and Augmentative communication (AAC) devices 18. Facility AAC screening forms 19. Facility AAC-related database reports/spreadsheets 20. Facility list of general common area AAC devices 21. Facility list of individuals receiving direct communication-related intervention plans 22. Competency Based Training Forms for staff in sample 23. Skill Acquisition Plans for individuals 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 5/7/2014, and Action Plan dated 5/7/2014. 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 all provisions. This was inconsistent with the Monitoring Team's findings of compliance with 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. o The monitoring tools did include adequate methodologies, such as observations, record review and staff interview. The Facility also provided an Action Plan to move toward compliance. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: Provision R.1 was found to be in substantial compliance. 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. **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. It should be noted that timeliness had shown great improvement post December 2014, which coincides with the date that RGSC returned to full staffing. Another observation regarding the assessments is that they had shown great improvement in identifying opportunities for individuals to utilize the general area AAC devices. The problem noted was that these recommendations were not consistently implemented by staff as noted in Provision R.3 or were not integrated into the other skill acquisition plans (SAPs) and service objectives in

	which the individual was involved 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. The Speech Therapists were actively and consistently monitoring individuals with AAC as well as the general area devices but the results of the monitoring were not well represented as part of the ISPA or QIDP monthly notes. The Speech Therapists had implemented a system by which 10 individuals were being monitored monthly for effectiveness and compliance. In addition, all the communication related SAPs were reviewed by the SLP. Again, the primary concern was that there was lack of evidence regarding the sharing of information as reflected in lack of consistent ISPA documentation.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	Samples for this section are as follows: Sample R.1: Consisted of seven 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 three 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 remain in substantial compliance. While staffing has remained the same since the previous review, evidence still shows and staff still express 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 individuals, which appeared to be reasonable to conduct the daily activities and responsibilities of the SLP.	Substantial Compliance

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		Qualifications: Two of two positions for SLPs (100%) were filled by licensed SLPs 1. Two of two SLPs (100%) were licensed to practice in the state of Texas. **2.** 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: **1.** The Annual Habilitation Conference **2.** Aspiration Pneumonia and the role of the SLP It should be noted that attendance at the Summer Conference for the Texas Assistive Technology Network was requested but had not been authorized as of this review. Attendance at such a conference would greatly assist the SLPs at RGSC as this is a primary area of focus of the SA and one that greatly impacts the lives of the Individuals. Facility Policy 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. RGSC provided a policy titled "Communication Services" that was last revised in October 2013. The following components were included in this policy: 3. Roles and responsibilities of the SLPs (meeting attendance, staff training etc.) 4. Outline of assessment schedules 5. Frequency of assessments/updates ~~6.~~ Timelines for completion of new admission assessments 7. Timelines for completion of comprehensive assessments 8. Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication 9. Process for effectiveness monitoring by the SLP 10. Criteria for providing an update 11. Process for effectiveness monitoring by the SLP 12. Methods of tracking progress and documentation standards related to intervention plans **13.** Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem	

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		resolution 14. Monitoring for the presence of communication adaptive equipment or other AAC supports/materials 15. Monitoring for the working condition of communication adaptive equipment 16. Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work) **17.** The frequency of monitoring for individuals within the established Master Communication Plan priority levels 18. The process for identification, training, and validation for monitors 19. The process of inter-rater reliability	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	<u>Assessment Plan:</u> The Facility had a reasonable plan to screen all individuals and, based on priority need, assess individuals who would benefit from the use of alternative or augmentative communication systems. RGSC provided assessments for all new admissions. Individuals at a minimum were provided with a Comprehensive Communication Assessment every three years along with an annual update should the individual be provided with direct or indirect services related to communication. Part of the annual update was a review of all areas within the assessment including but not limited to expressive and receptive language, medications, and vision and hearing. Additionally a screening was conducted as part of the communication update to further determine if there had been a change in status that would warrant another comprehensive assessment. <u>Assessments Provided</u> Seven individuals in Sample R.1 (100%) were provided a communication assessment per policy. 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 other individuals. Four of four admitted individuals (100%) since the last review received a communication screening or assessment within 30 days of admission or readmission. Four of four individuals (100%) assessments were posted a minimum of five days before the admission ISP meeting. For eight of 13 individuals in Samples R.1, R.2, R.3, and R.4) (62%), 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		ISP document. It should be noted that 100% of the assessments completed post January 2014 were completed in a timely manner. 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: • Seven of seven (100%) were signed and dated by the clinician upon completion of the written report; • Four of seven individuals' speech and language assessments (57%) were dated as completed at least 10 working days prior to the annual ISP; • Seven of seven individuals' speech and language assessments (100%) included diagnoses and relevance of impact on communication; • Seven of seven individuals' speech and language assessments (100%) included individual preferences, strengths, and needs; • Seven of seven individuals' speech and language assessments (100%) included medical history and relevance to communication; • Seven of seven individuals' speech and language assessments (100%) listed medications and discussed side effects relevant to communication; • Seven of seven individuals' speech and language assessments (100%) provided documentation of how the individual's communication abilities impacted his/her risk levels; • Seven of seven individuals' speech and language assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day. • Seven of seven individuals' speech and language assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); • Seven of seven individuals' speech and language 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; • Seven of seven individuals' speech and language assessments (100%) included discussion of the expansion of the individuals' current abilities. • Seven of seven individuals' speech and language assessments (100%) provided a discussion of the individuals' potential to develop new communication skills.	

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		• Six of seven individuals' speech and language assessments (86%) 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. On 11/26/12, Individual #74 was identified as needing to receive an AAC review to determine type of equipment that would be beneficial. As of 5/22/14, the therapists still have not made a clear determination regarding the plan of care as the evaluation conducted on 10/23/14 stated that the evaluation continues to determine best output device. • Seven of seven individuals' speech and language assessments (100%) offered a comparative analysis of health and functional status from the previous year • Seven of seven individuals' speech and language assessments (100%) gave a comparative analysis of current communication function with previous assessments • Seven of seven individuals' speech and language assessments (100%) 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. • Seven of seven individuals' speech and language assessment (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; • Seven of seven individuals' speech and language assessments (100%) had a reassessment schedule; • Seven of seven individuals' speech and language assessments (100%) supplied a monitoring schedule. • Seven of seven individuals' speech and language assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits. • Seven of seven individuals' speech and language assessments (100%) made a recommendation about the appropriateness for community transition. • Two of seven individuals' speech and language assessments (29%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. The assessments primarily restated that staff should be encouraged to use strategies throughout the day but failed to identify how the SAPs could be modified to reflect Communication strategies such as those listed in the communication dictionary. It should be noted that two of the speech and language assessments were written on the old speech and language template which does not reflect the subsection that is being referenced. Overall, the speech assessment continued to show improvement but still needed to do a	

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		better job in providing better guidance into how strategies and recommendations should be integrated into the daily schedule. This includes integration into other SAPs and not just providing direction regarding use of general AAC devices. It should be noted that per review of the ISPs it was clearly evident that the SLP has become much more vocal in providing information regarding the individuals' status of communication and how staff can better bridge any communication gaps. In order to obtain substantial compliance, the speech and language assessment must be completed in a timely manner and show review and integration of communication skills into the other generated SAPs. Seven of seven updates/assessments (100%) were completed consistent with the established schedule, or the individuals' need. <u>SLP and Psychology Collaboration:</u> 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%). Although the SLP at the time of the review continued to not participate 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, the Facility implemented an effective way that was identified to address the concerns was 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 appeared to be working well as evidenced by the increased integration and collaboration of the plans of care.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three	<u>Integration of Communication in the ISP</u> Based on review of the ISPs for individuals in Sample R.1 the following was noted: • In seven of seven ISPs reviewed (100%) for individuals with communication	Noncompliance

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	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.	needs an SLP attended the annual ISP planning meeting. • Seven of seven 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 seven of seven 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. • Zero of four ISPs reviewed (0%) included how communication interventions were to be integrated into the individual's daily routine. The other three individuals were independent with communication. • Four of four ISPs reviewed (100%) contained skill acquisition programs to promote functional communication. The other three individuals were independent with communication. • Seven of seven ISPs reviewed (100%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. <u>Development And Implementation Of Functional Individual-Specific Assistive Communication Systems</u> No revisions were recommended for the communication dictionaries; therefore whether modifications were made in a timely manner could not be determined and will be reviewed at the next visit. Observations were conducted in homes for individuals with AAC systems in Sample R.4. Findings included the following: • Two of five observations (40%) found AAC devices present in each observed setting and readily available to the individual. • AAC systems for one of five individuals (17%) were noted to be in use in each observed setting. As with review of the general devices, opportunities in which the device could be utilized occurred during the observations. These included Voc Ed, time of transition, as well as conversation that should occur as part of meals. • AAC systems for five of five individuals (100%) were portable. • AAC systems for five of five individuals (100%) were functional. • For five of five individuals (100%), staff instructions/skill acquisition plans related to the AAC system were available. <u>General Use AAC Devices:</u> RGSC had 70 common/general area shared devices available for use throughout the	

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		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 three of three areas and other environments, 67 of 70 (96%) general use AAC devices were operational. This represented a substantial improvement since the previous compliance visit. • Sixty of the 70 general use AAC devices (86%) noted contained clear directives on how staff should use these devices. This represented an increase of 17% since the previous visit. • Seventy of 70 general use AAC devices (100%) had a clear function within that setting/situation. • Zero of three observations (0%) noted general use AAC devices were consistently used. Observations were provided in which there were multiple opportunities to use the board and devices (for example: mealtimes, washing hands, oral care). Staff were observed utilizing the "wash hands" button in the dining room but staff were not following the instructions on how to present and utilize the device. <u>Direct Communication Interventions</u> Review of the individuals' records from Sample R.2 showed the following: • Three of 3 individuals' 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 three of three individuals' records (100%) reviewed, the current SLP assessment identified the need for direct intervention with rationale. • For three of three individuals' records (100%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. • For three of three individuals (100%), 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 reported on a monthly basis how the goal would support communication for the individual in their daily activities. • For three of three individuals (100%), a report was found regarding the consistency of implementation.	

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		• For three of three individuals (100%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. • For three of three individuals (100%) progress notes contained the consistency of implementation. • For zero of three individuals (0%) progress notes occurred at a minimum monthly. While data sheets were evident, there lacked clear notes regarding success with objectives and if plan of care remained appropriate. <u>Indirect Communication Supports:</u> Programs for individuals in Sample R.1 who received indirect communication supports were reviewed. • Six of six (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. • In six of six individuals' records (100%) reviewed, the current SLP assessment identified the need for indirect intervention with rationale. For six of six individuals in Sample R.4 (100%), 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 six individuals (0%) receiving indirect Speech Services (Sample R.4) were provided with comprehensive progress notes that contained each of the indicators listed below. • Quarterly documentation for zero of five individuals (0%) contained information regarding whether the individual showed progress with the stated goal(s) or objectives. • Quarterly documentation for zero of five individuals (0%) identified the benefit of device and/or goal(s). • Quarterly documentation for five of five individuals (100%) identified consistency of implementation. • Quarterly documentation for zero of five individuals (0%) identified recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress. An overall concern noted was the lack of consistent data gathered to allow for adequate review and revision of the goals. This was pervasive issue that plagued all SAPs and not just those related to Speech. For example, Individuals #97 and #98 both had extensive data points missing throughout the month and quarter.	

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		Another concern was that data was not consistently reviewed in a timely manner as it was reported by the SLPs that they often fell behind and were not able to consistently review the data from indirect therapies. This is an area in which the QIDPs could assist in the review and monitoring of the plan since it is not implemented by the SLP but as part of a Communication SAP. <u>Staff Interviews</u> Three of six staff interviewed (50%) were knowledgeable of the individual and their communication related programs; direct support professionals had difficulty with the following questions • Whether there was a communication program. • Describing the communication program goal. • Described the schedule for implementation of the communication program. • Identifying how communication skills in the program were addressed throughout the day. <u>Competency-Based Training and Performance Check-offs:</u> Based on review of the NEO training curriculum, RGSC did develop comprehensive competency based training regarding communication services. • The training materials reviewed did address all the appropriate content areas listed below: o Methods to enhance communication o Implementation of programs o Benefits and use of AAC o Identification of non-verbal means of communication. Forty-eight of 48 new employees (100%) had completed NEO core communication competencies for foundational skills and performance check-offs since the last review. <u>Individual-Specific Competency-Based Training</u> To determine whether the Facility had a process to ensure 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. One of two (50%) individual's staff assigned had completed competency check-offs regarding the individuals' communication programs. Not all staff for Individual #84 were provided with the necessary training. It was reported on 2/12/14 that there were four "no shows" but there was no evidence that follow up was provided to ensure the "no	

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		show" staff were eventually trained. Staff responsible for training other staff were Speech Therapists (SLPs), who were competent to train other staff regarding implementation of the device. SLP's train Floor Supervisors and primary, secondary and floater staff to competency; this includes written exam of the program and return demonstration, which requires a passing score of 80% or above. The Floor supervisors are given the exam and return demonstration forms to continue the training process to other staff. The Floor supervisors initial acknowledgment on the training roster that the will continue training until all staff are trained. They must submit all training rosters to the training coordinator as evidence that the training occurred.	
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.	<u>Policy and Procedure</u> A Facility policy and/or procedures 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. <u>Monitoring of Implementation of Communication Supports</u> The Monitoring Team reviewed Compliance Monitoring forms for implementation of communication supports the last six months for six individuals from Sample R.4 and the following was found: • For six of six individuals (100%), monitoring of communication supports was outlined in the assessment. • For six of six individuals (100%) monitoring of their communication supports occurred at the frequency established by Facility policy or ISP. AAC monitoring was conducted that focused on presence and working condition, but this monitoring lacked consistent review of whether the plans/devices remained appropriate or the frequency in which the devices were being utilized. Per observations, underutilization of the devices was an area of concern noted by the Monitoring Team. Zero of six individuals from Sample R.4 (0%) received monthly and/or quarterly monitoring to ensure all communication supports remained effective and functional. Although there was no monthly review by the QIDP, at RGSC, the SLP did provide review of ten individuals monthly to determine effectiveness and functionality in addition to following all individuals who had SAP to determine the need for modification and/ or complete revision. The concern noted was that the results were not represented	Noncompliance

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		consistently as part of the ISPA. There was some discussion noted as part of the ISPA but it lacked the needed information to qualify as a full review. (See R.3-Indirect Supports for additional information) 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 if plans are resulting in functional gains or skills.	

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 – 5/7/2014 2. RGSC Action Plan – 5/7/2014 3. RGSC Presentation Book for Section S 4. Requested documents included the annual ISP, ISP addenda (ISPAs), Skill Acquisition Plans (SAPs), Positive Behavior Support Plans (PBSPs), structural and functional assessments (SFAs), treatment data, teaching data, progress notes, psychology and psychiatry evaluations, physician's notes, psychotropic drug reviews, consents and approvals for restrictive interventions, safety and risk assessments, task analyses, and behavioral and functional assessments. All documents, where available, were reviewed in the context of the Self-Assessment. Documents were requested for the following Individuals: Individual #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. 5. ISPs for Individuals #82 and #94 **People Interviewed:** 1. George Romero – QIDP Coordinator 2. Approximately 15 direct care staff in both Facility residences as well as vocational and day treatment areas. **Meeting Attended/Observations:** 1. 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. Based upon the problems encountered in obtaining the documents requested as part of the site visit, the validity and accuracy of the Facility's Self-Assessment was brought into question. Developing a comprehensive and accurate self-assessment requires that all relevant documents and data be current, well organized, and accessible. Despite requests, many requested documents were not made available. No specific reason was provided for the missing documents. The documents that were not submitted included documents essential to the Self-Assessment process, including skill assessments and skill acquisition plans. If these documents were not available for submission to the Monitoring Team, it was unlikely that they would have been available for the development of the Self-Assessment. It is recommended that the Facility take all necessary action to ensure that records are current, organized, and accessible.

	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 S.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at RGSC from 5/19/2014 through 5/23/2014. Record reviews continued off-site following the site visit. The process of completing the assessment of Section S was complicated substantially by the difficulty in obtaining the documents essential to the review process. As noted elsewhere in this report, not all requested materials were submitted. As a result, no skill acquisition plans and only limited numbers of assessment reports were available for review. Based upon observations conducted during the site visit, it did appear that functional engagement had continued to increase. Problems were noted, however, in the provision of skill acquisition plans to be implemented in the community. In addition, data collection for skill acquisition plans at the Facility was infrequently conducted, and when conducted was often recorded incorrectly.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all	<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 the August 2011 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. In October 2013, improvements were noted 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.	Noncompliance

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	individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Current Site Visit During the current visit, the Facility was asked to provide ISP documentation, as well as associated assessment reports and skill acquisition programs, for 10 individuals living at the Facility. Included in this request were Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. No skill acquisition programs were made available to the Monitoring Team. Without the requested skill acquisition programs, it was not possible to review the quality of skill acquisition programs or the manner in which assessment information was used in the development of such programs. Engagement, activities, and informal skill acquisition training The Monitoring Team conducted observations in a variety of settings across the Facility. The table below reflects the number and percentage of individuals who were engaged in any formal or informal activity that did not include stereotypic movement, self-stimulation, or other undesired behavior.	

	Staff Present	Individuals Present	Individuals Functionally Engaged	Percent Functionally Engaged
Vocation Room 24	1.00	3.00	1.00	33%
Vocation Room 21	1.00	3.00	3.00	100%
Vocation Room 18	1.00	4.00	1.00	25%
Vocation Room 12	2.00	7.00	5.00	71%
Vocation Room 8	2.00	5.00	5.00	100%
Vocation Room 511	1.00	3.00	3.00	100%
Vocation Room 511	1.00	3.00	2.00	67%
502 Dining Room	5.00	6.00	6.00	100%
502 Dining Room	4.00	5.00	4.00	80%
501 Dining Room	4.00	5.00	5.00	100%
501 Yard	1.00	1.00	1.00	100%
502 Foyer	3.00	2.00	2.00	100%
Total percentage of individuals functionally engaged				84%
Percentage of locations with 50% or greater functional engagement				80%

Observations revealed that across all settings 84% of observed individuals were functionally engaged. Furthermore, more than three-quarters (80%) of all environments observed reflected at least 50% engagement. Specific circumstances noted during observations included the following.

- In the 502 Dining Room, one staff demonstrated exceptional skill in implementing a dining program. Her efforts included prompts, redirects, and consistency in implementation.
- In the 511 Vocational building, staff and individuals worked well together in bagging

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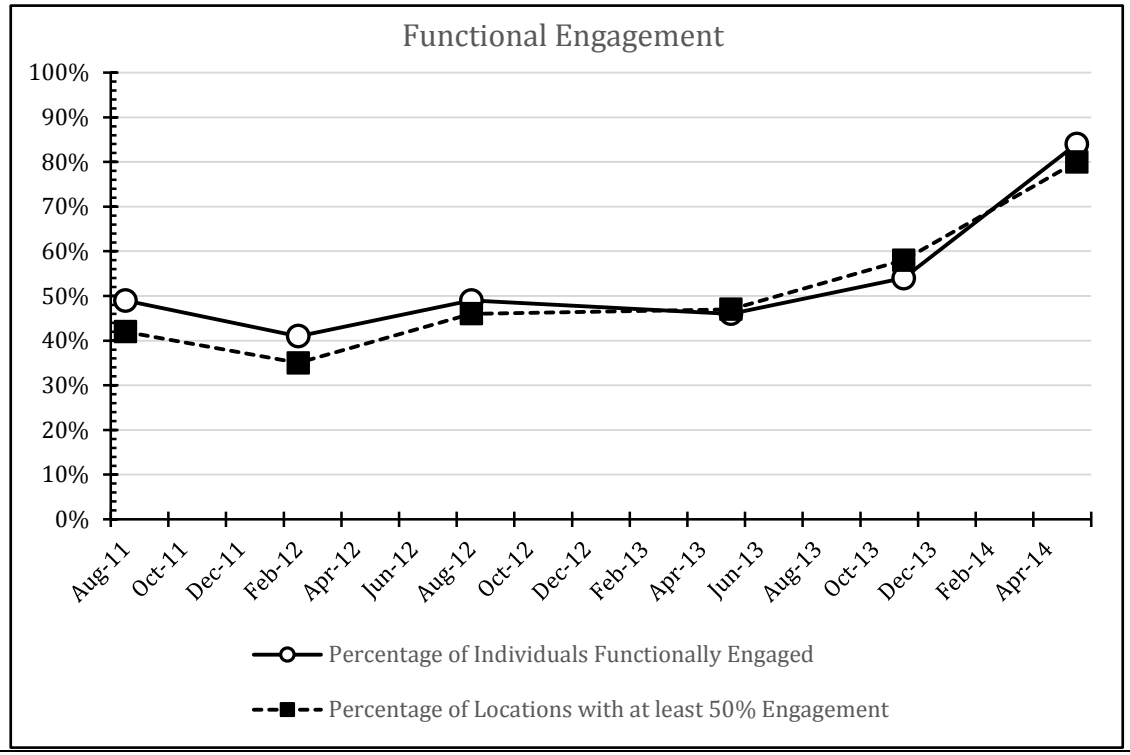
		landscaping gravel. Individuals were self-motivated, but staff was observed effectively using prompts to shape skills. Not all observations conducted at the Facility reflected high levels of functional engagement. In a few settings, staff did not provide the materials and attention necessary to maintain reasonable levels of functional engagement. • An individual in the 501 Dining Room was observed to consume seven large spoonsful of food rapidly. The dining plan called for the individual to be provided prompts to sit up, use small bites, and to drink between bites. No prompts were offered until after the Monitor requested to view the individual's dining card. Following the request to view the dining card, staff offered only occasional prompts to slow down. • An individual in the 502 Dining Room was observed to be slouched over and drooling on the table. After being served his meal, the individual eats and drinks while slouched over with forearms resting on the table. The individual's dining plan called for prompts to sit upright as well as for staff to monitor bite size. No prompts or monitoring were observed during the meal.  	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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The Monitoring Team also reviewed skill acquisition data for current training programs. DSP staff in various locations was asked to provide the program data books for at least three individuals. Alternating between individuals, the data sheet for the first or second skill acquisition program in the data book was selected for review. This resulted in 16 training programs for 14 individuals being included in the sample. These individuals included Individuals #5, #12, #21, #31, #33, #55, #61, #77, #97, #98, #103, #115, #139, and #140. Individuals #97 and #139 were included in the sample twice as their program books were selected by staff in two separate locations.

Based upon the findings of the of the skill acquisition data review, it was evident that substantial weaknesses existed in the procedures for collecting skill acquisition data.
• Two of 16 training data sheets (12%) were missing from the training data books.
• Data sheets were lacking current data for 12 of 16 training programs (75%).
• Data were recorded incorrectly on 14 of 16 data sheets (87%).

Findings from the review of skill acquisition data were shared with the Facility. The Facility indicated data sheets were often removed due to damage and other issues, creating the impression that data collection was incomplete. The Monitoring Team was assured that additional data sheets would be made available that reflected the removal of data sheets. Despite a written request, additional data sheets were not made available by the Facility.

Based upon information obtained from observations and document reviews, it appeared that the Facility had continued to improve the provision of functional engagement. It was not evident, however, that increased functional engagement included consistent and ongoing provision of formal skill acquisition training. Functional engagement alone may enhance quality of life but formal skill development training is needed to promote the development of skills necessary for increased independence most effectively. Therefore, although the Facility should be commended for the enhancement of functional engagement, it must be recognized that the Facility fell far short of the obligation to provide comprehensive skill acquisition training.
</td><td></td></tr>
<tr><td>S2</td><td>Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure</td><td>
During the current visit, the Facility was asked to provide ISP documentation, as well as associated assessment reports and skill acquisition programs, for 10 individuals living at the Facility. Included in this request were Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. As reflected in the table below, for no individual were more than 43% of the required assessment reports submitted. Furthermore, none of the 14 types of assessment reports (0%) was submitted for all individuals in the sample.

<table>
<tr><td>Assessments</td><td colspan="10">Individuals</td><td></td></tr>
<tr><td></td><td>#6</td><td>#27</td><td>#28</td><td>#55</td><td>#59</td><td>#63</td><td>#77</td><td>#84</td><td>#98</td><td>#139</td><td></td></tr>
<tr><td>Communication</td><td>N</td><td>N</td><td>N</td><td>N</td><td>N</td><td>N</td><td>N</td><td>N</td><td>N</td><td>N</td><td>0%</td></tr>
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</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status											Compliance
	activities.	Functional Skills Assessment	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	90%	
		Integrated Risk Rating Form	Y	N	Y	Y	Y	Y	N	Y	Y	Y	80%	
		Medical	N	N	N	N	N	N	N	N	N	N	0%	
		Nursing	N	N	N	N	N	N	N	N	N	N	0%	
		Occupational/Physical Therapy	N	N	N	N	N	N	N	N	N	N	0%	
		Preferences and Strengths Inventory	N	Y	Y	Y	Y	Y	N	N	Y	Y	70%	
		Psychiatric	Y	N	N	N	N	N	N	N	N	N	10%	
		Psychological	Y	Y	Y	Y	Y	Y	N	Y	N	Y	80%	
		Rights	N	N	N	N	N	N	N	N	N	N	0%	
		Self-Administration of Medication	N	N	N	N	N	N	N	N	N	N	0%	
		Structural Functional Assessment	Y	Y	Y	Y	Y	Y	N	Y	N	Y	80%	
		Task Analysis	N	N	N	N	N	N	N	N	N	N	0%	
		Vocational	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	90%	
			43%	29%	43%	43%	43%	43%	7%	36%	29%	43%	0%	
		It was not possible to determine if the submitted assessment reports included all completed assessment reports. In some cases, assessment reports submitted by the Facility following the initial request were not included in the submission following the final document request that was made to ensure that all pertinent documents had in fact been submitted. Based upon the material provided by the Facility, it did not appear that the assessments required under Provision S.2 had been completed as stipulated.											
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:												

#	Provision	Assessment of Status	Compliance
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	During the current visit, the Facility was asked to provide ISP documentation, as well as associated assessment reports and skill acquisition programs, for 10 individuals living at the Facility. Included in this request were Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. Despite one document request submitted on-site, as well as two follow-up requests submitted following the site visit, no skill acquisition programs were made available to the Monitoring Team. Without the requested skill acquisition programs, it was not possible to review the quality of skill acquisition programs or the manner in which assessment information was used in the development of such programs.	Noncompliance
	(b) Include to the degree practicable training opportunities in community settings.	At the time of the current site visit, the Facility reported that 47 of 66 individuals (71%) had been provided skill acquisition plans that were to be implemented in the community. During the site visit, the Facility was asked to provide copies of community-implemented skill acquisition programs for 10 individuals living at the Facility. Included in this request were Individuals #6, #27, #28, #55, #59, #63, #77, #84, #98, and #139. Despite one document request submitted on-site, as well as two follow-up requests submitted following the site visit, no community skill acquisition programs were made available to the Monitoring Team. Without the requested skill acquisition programs, it was not possible to review the content or quality of these training programs. A summary of community skill acquisition programs was provided by the Facility for the 47 individuals indicated to have community skill acquisition programs. Based upon this summary, it appeared that 46 of the 47 programs (98%) targeted money management skills. It was positive that the Facility had implemented training in the community. In addition, money management is an important skill. Money management alone, however, will not prepare an individual to live more independently in the community. It would be beneficial for the Facility to expand community skill acquisition training to other skills, such as identifying the correct restroom, identifying nutritional foods, work and social skills needed for working in integrated settings, and asking for directions. It should be noted that of the 47 skill acquisition programs listed for community implementation, 10 (21%) were over a year old at the time of the site visit. During the previous site visit, 25% of community training programs were over a year old. The Monitoring Team reviewed recent ISPs for Individuals #82 and #94. • Neither of the two ISPs (0%) reviewed included a specific skill acquisition action plan 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. Individual #94 had a SAP to hand money to a cashier for purchases in	Noncompliance

#	Provision	Assessment of Status	Compliance
		the community, but the Action Plan specified no expectation as to how often this would occur. Neither did it reference the individual's enjoyment of having nails and hair done or shopping for clothes. It might have been useful to integrate into the SAP a plan that opportunities will be provided monthly to hand money to a cashier when the individual gets hair or nails done (in addition to other times). • Individual #82 had no SAPs to be implemented in the community, nor any specific Action Plan for community participation. The IDT noted in the ISP that Individual #82 enjoyed a number of community activities, but there were no community Action Plans related to these leisure interests. The only references to community participation was for the Special Considerations to be revised to indicate the individual would be encouraged to shake hands in greeting in all settings, as well as for staff to use the individual's communication strategies in all settings. The Facility reported that community outings were conducted on a routine basis. Documentation provided for April 2014 reflected that a total of 67 community outings were provided. The following information was available regarding these 67 outings. • An average of 4.3 individuals participated in each outing. • On an individual basis, participation in outings ranged from 0% of outings to 49% of outings. • Documentation reflected that 17 of 69 individuals (25%) participated in no outings during April. The Facility reported no individuals engaged in employment in the community.	

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 5/7/14 2. RGSC Action Plans 5/7/14 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 004.2 Individual Support Plan Process and attachments (11/21/13) 7. RGSC SOP ICF-MR 200 01 Most Integrated Setting (December 2013) 8. Individual Support Plans (ISPs) and Supporting Documentation for Individuals #82 and #94 Documentation requested included: a. The full ISP document, b. All assessments considered during that ISP development process, c. The Preferences and Strengths Inventory (PSI), d. MRA CLOIP Assessment Worksheet or most recent Permanency Plan, e. Sign in sheets showing IDT members attending the ISP meeting, f. Any ISP addendums, g. All associated skill acquisition/teaching programs, h. Completed Rights Assessment, and i. Completed Decision-Making Functional Capacity Assessment. j. The last three monthly reviews; k. The last two quarterly reviews; l. Individual's daily schedule; m. Special Considerations list; and n. Third quarterly meeting documentation. 9. "ISPs Addressing Living Options" for Individuals #5, #11, #29, #51, #62, #79, #97. #101, #103, and #114 10. Community Placement Report 11/1/13-4/25/14 11. 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 12. 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 13. Since the last on-site review, a list of individuals whose referral has been rescinded, including the reason and all related ISPA documentation 14. ISP Addendums (ISPAs) addressing rescinded referrals for Individuals #29 and #72

	15. 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." 16. For the past year, a list of all individuals who have died after moving to the community 17. 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 18. ISPA following return of Individual #62 19. 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 20. A current list of all alleged offenders committed to the facility following court-ordered evaluations 21. For the last twelve months, a list of all individuals who have been assessed for placement, date of assessment, and resulting recommendation(s) 22. 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. 23. Invitations to families/LARs for Provider Fair 24. Invitations to private providers for Provider Fair 25. Training/Course Sign-In Sheets for Provider Fair 3/26/14—Individuals, Providers, Families, and Staff 26. Community Transition Process training outline and sign-in sheet 27. Continuity of Care Training for Nurse Case Managers and training roster 28. Schedule of Events Compiled by Armando Cobos, Transition Specialist for RGSC 29. RGSC Tour Survey November-May 30. Invitations to Family/LAR to tour Community Private Providers 31. Self-Advocacy Meeting Presentation of Video on Group Homes & Nomination of Officers Sign-in Sheet 32. Minutes of Self-Advocacy Group Meetings of 11/20/13, 12/17/13, 1/21/14, 1/27/14, 2/1/14, 2/26/14, 3/20/14, and 3/26/14 33. Since the last compliance visit, copies of documents or written materials provided to staff to inform them of community living opportunities 34. Community Living Options Information Process (CLOIP) Documents for Individuals #5, #11, #29, #51, #62, #79, #97. #101, #103, and #114 35. Community Living Discharge Plans (CLDPs) for Individuals #101 and #149 36. CLDP Assessment Checklist blank form (undated) 37. CLDP Checklists for Individuals #60, #101, and #149 38. Family invitations to CLDP meetings for Individuals #60, #101, and #149 39. 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 #101, #132, and #149 40. For Individuals #101 and #149: a. Pre- and Post-Move Monitoring Checklists completed by RGSC 41. Since last on-site review, a list of all individuals returned from a community residential placement and documentation of the Facility's review and assessment

	42. Potentially Disrupted Community Transition (PDCT) Process (8/29/13) 43. Reports showing analysis of monitoring/audit data or other data in relation to the provision of supports in the most integrated setting, and descriptions of actions taken 44. Annual Report: Obstacles to Community Transition, Rio Grande State Center, Fiscal Year 2013 45. Section T key indicators **People Interviewed:** 1. Alma Ortiz, Admission/Placement Coordinator (APC), Armando Cobos, Transition Specialist, and Rosa Sanchez, Quality Assurance **Meetings Attended/Observations:** 1. Post-Move Monitoring Visit for Individual #149 2. ISP Annual Planning Meetings for Individuals #126 and #140
	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: ▪ Living Options Monitoring Tool ▪ Community Living Discharge Plan (CLDP) Monitoring Tool o The Self-Assessment did not consistently identify the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population. There was no statement of the sample size for the Living Options Monitoring Tool. o The staff/positions responsible for completing the audit tools were not specified. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. • Used other relevant data sources and/or key indicators/outcome measures, including: o Number of individuals, families, and staff who participated in Provider Fair, community tours of alternate living environments, and other events o • The Facility consistently **presented/did not present** data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Did not present findings consistently based on specific, measurable indicators. For example: ▪ For Provision T.1.b.1, data from the Living Options Monitoring Tools were not provided; instead, the results were a list of conclusions. ▪ For Provision T.1.b.3, the data were not provided for the two activities.

	○ Did not consistently measure the quality as well as presence of items. For example, the results reported for Provision T.1.b.1 not only did not include data on the percent of tools on which each criterion was met, but also did not assess the quality of the required activities (such as whether the IDT not only identified individualized supports but also ensured all supports needed for health and safety were included). For Provision T1d, the Facility assessed the timeliness but not the quality of assessments. • The Facility rated itself as being in compliance with the following provisions of Section T: Provision T1b, Provision T1c2, Provision T1d, Provision T1g, Provision T1h, 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 T1c2, Provision T1c3, Provision T1h, and Provision T2b (which the Facility could not rate). For Provision T1d, assessments were timely, but problems with quality were found. For Provision T1g, the Facility accurately assessed that it had complete the Obstacles Report but did not address the other requirements of the provision—that both the Facility and DADS will analyze the information, and that DADS will take appropriate steps to overcome or reduce obstacles. 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, Not Started, or Scheduled as Needed. Those described as Scheduled as Needed are actually ongoing processes, as are some In Process actions, rather than being new initiatives or improvements needed to move closer to substantial compliance. For example, an action to "Identify all the protections, services, and supports to ensure safety of the Individual in the most integrated setting, during their annual ISP meetings scheduled each month" is an ongoing activity. The Facility needs to develop actions to improve the identification of necessary supports, as the Facility stated in its Self-Assessment for Provision T1a. • The Facility data identified areas of need/improvement. For example, the Facility identified that "IDT members continue to need more direction and guidance in identifying supports and protections." • The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. For example, although finding that IDT members need more direction and guidance in identifying supports and protections, the Action Plan simply continues the current process. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities. As one step in doing this, the Facility should carefully review the findings in this report.
	Summary of Monitor's Assessment: The Facility continues to assist individuals to move to more integrated settings, although the pace has slowed somewhat. It remains less clear that progress is being made toward identifying the supports and

	protections individuals would need to transition successfully and to making those clear in transition planning. **Provision T1:** Two individuals had transitioned in the past six months, and one additional individual was scheduled to transition in the week following the compliance visit. Overall, RGSC needed to improve its processes to adequately assess, plan for, and implement a plan for each person's needs for education and awareness about community living options. The Monitoring Team encourages the Facility to continue to work toward development of an individualized education/awareness strategy for each individual that takes into account his or her specific learning needs. Continuing deficits in assessments also translated to instances in which the IDT 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, or the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and the strategies intended to overcome such obstacles. In turn, these deficits continued to be apparent in CLDPs that did not adequately reflect the protections, services and supports an individual would need to make a successful transition to community living. Determination by IDT clinicians and the IDT as a whole of appropriateness of referral for transition to a more integrated setting also needs to improve. CLDPs identify timelines and staff responsible, and include documentation that they have been reviewed with the individual and/or LAR. Discharge assessments are timely but need to be more comprehensive. **Provision T2:** It appears that post-move monitoring is done well, but the documentation is not clear enough to verify that. The Post-Move Monitoring Checklists did not have information adequate to be certain of how supports were checked and whether actions had been taken (both by the Facility and follow-up by the post-move monitor). Observation of a post-move monitoring visit indicated a compliant process that was not well-documented in the Checklist.

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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	<u>Policies and Procedures related to Movement to the Most Integrated Appropriate Setting:</u> RGSC SOP ICF-IID 200 01 establishes the principles and procedures of encouraging and assisting individuals to move to more integrated settings. The policy was revised in December 2013. <u>Transition Outcomes During Last Six Months:</u> • Community Transitions: o Based on the Community Placement Report and information provided during the compliance visit, two individuals transitioned to community living (3% of population). This compared to three individuals during the prior report period. One additional individual was scheduled to	Noncompliance

#	Provision	Assessment of Status	Compliance
	professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	move the week following this visit. o Review of the Community Placement Report indicates both these individuals transitioned within 180 days of being referred. However, the accuracy of this is unclear, as the Community Placement Report provided for the last compliance visit provided a referral date more than one year prior for Individual #101. • <u>Referrals for Community Transitions</u> o According to the Community Placement Report, five individuals were on the current referral list (8% of population). Four of these individuals were referred since the last compliance visit (including one individual whose referral had been rescinded due to a medical reason and who was referred again when the medical issue was resolved). This number was comparable to the number reported at the last visit. Of these five individuals on the referral list, one (20%) had been on the list for more than 180 days. This individual was scheduled to move the week following this compliance visit. • Individuals requesting placement, but were not referred: The Facility reported there were no individuals who had requested placement but were not referred. • Rescinded Referrals: o There were three rescinded referrals reported since the last review. o Of these, the reasons for the rescinding appeared to be reasonable for two (67%). The Facility documented ISPA meetings for two of three individuals (67%) and noted the third was not available at the time of the document request (but did not provide it later). The referral for Individual #72 had been rescinded due to a medical reason, with a plan to meet again to discuss referring, and the individual was referred again when the medical issue was resolved. The referral for Individual #127 was rescinded due to behavioral issues and medication changes. Rescinding the referral for Individual #29 was more questionable. This individual's family was seeking guardianship and wished the individual to continue to live at RGSC. The individual had been served with court documents to appear. The Facility did not provide documentation of discussion with the family to determine reasons for wishing the individual to continue to live at RGSC, nor of any individualized plan to address those issues. Given that the individual did not yet have a guardian, and the Facility had not addressed concerns of the family, it is questionable whether the referral should have been rescinded. The IDT did provide an appropriate rationale for its decision. • <u>Outcomes of Transitions</u> o <u>Returns from Community Placement</u>	

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		▪ Individual #62 returned after six months in community living. The Facility provided an Admission Meeting ISPA. This gave a summary of the events leading to the individual's return but did not document discussion about what the Facility might do in the future to address the issues that had arisen, either for the individual or as part of transition planning in general. The Facility reported a review to determine recommendations for changes to the transition process in general occurs through the Facility QA process but did not provide documentation that such a review had occurred. o Deaths Following Community Placement: The Facility reported there had been no deaths of individuals who had moved since 7/1/09 to more integrated settings. o Other Adverse Outcomes: The Facility did not report any other adverse outcomes or issues that might disrupt transitions for individuals who had moved, nor did the Monitoring Team become aware of any through review of PMM documentation or observation of a PMM visit. Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting: Based on review of documentation and interviews with staff, there were systemic issues that delayed or might have delayed transitions. These included: • Lack of funding due to lack of citizenship. As reported in Provision U2, the Facility had begun to explore the naturalization process. This remains an issue for DADS to address on a statewide level. • There is a need for more homes. Providers must wait to have enough individuals interested before they can get homes. Homes are not regularly available in some smaller towns where individuals would like to move. This is an issue that DADS would need to address. • Only one provider in the local community provides employment services; the remainder provide only day habilitation. This can be a barrier for individuals who wish community work. The Facility should work with the Local Authority to identify this issue and seek development of more employment services. • The need for programs that can support individuals with significant behavioral support needs. The Facility did not provide information regarding actions it may be taking to assist in addressing the need for such supports. • The Self-Advocacy program included self-advocacy training in conjunction with a community provider agency, giving a few individuals the opportunity for regular contact with others who lived in more integrated settings. For the larger group, one meeting during the prior review period had a focused presentation	

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		and activity about community placement. The Facility provided documentation of a video shown during the 5/13/14 Self-Advocacy meeting about group homes. The Facility reported this showed an individual who had a successful move. The attendance sheet listed 25 individuals who attended and provided comments about six of those individuals who indicated interest in group homes. Facility Process to Track and Trend Referral and to Take Improvement Actions: Senior management at the Facility was kept informed of the status of referral, transition, and placement of all individuals on the active referral list. The Admissions Placement Coordinator presented information regularly at the QA/QI Council meetings. The Facility provided a report of key indicators from November 2013 through April 2014. The data reported the number of individuals who moved, returned, moved within 180 days, toured group homes, and had PMM visits. Some data were questionable. For example, one 7-day PMM visit was reported for January, but no such visit occurred, as no individual transitioned in December or January. Also, no tours of group homes were reported in March and April; this was accurate (according to the Survey of Tours) for March, but at least one tour was held in April. It is important for the Facility to ensure the data are accurate so they can lead to appropriate decisions. For the one individual who had been on the referral list for over 180 days, the Facility did not provide documentation of ISPAs, and the Facility reported they had not consistently occurred. However, the individual was, as noted above, scheduled to move the week following this compliance visit. Conclusion: There was progress in this area, but the provision was found to be not yet in compliance. As detailed in the rest of this Section T and in Section F above, outcomes in the areas of assessment and planning for protections, services and supports (see Provisions F1c, F1d, F1e, F2a1 and F2ab); education for community awareness (see Provision T1b2); and transition and discharge planning (see Provisions T1c1, T1d, and T1e) negatively affected the ability of the Facility to effectively assist and encourage individuals to move to the most integrated setting. The number of referrals had not increased.	
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	Policies and Procedures related to transition and discharge processes: At parties' meetings in July 2012, the parties agreed that the Monitors would rate Provision T1b as just the development of an adequate policy. The sections T1b1 through T1b3 would be considered stand-alone provisions that require implementation independent of Provision T1b or any of the other cells under T1b. Since the previous visit, DADS had issued DADS Policy 018.2: Most Integrated Setting Practices, dated	Noncompliance

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	related to transition and discharge processes. Such policies, procedures, and practices shall require that:	10/18/2013. It did not address all of the items in section T of the Settlement Agreement. Below are comments from the Monitors: • The policy was missing a complete description of the process used to "assess" individuals for referral to the community. The ISP policy describes the process of team members making recommendations in their assessments (at III.C.5.c), but does not address having discipline members make a recommendation to the individual and LAR, followed by a full team recommendation being made. The ISP policy addresses, in very global terms, a "living options discussion," and refers the reader to the Most Integrated Setting policy for more details. T.1.b.3 states: "Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices." Neither policy, however, fully spells out how this will be done. • There was nothing requiring an individualized plan for the education of the individual and LAR. Such efforts are probably the most important aspect of addressing the primary reason for individuals not being referred (i.e., about 50% of the individuals across the state were not referred due to LAR preference). • The policy did not thoroughly address the IDT and Facility's responsibility in regard to identifying and addressing obstacles to referral and obstacles to transition. • There was no requirement that Facilities take action within their purview to overcome obstacles (e.g., working with local authority). • After referral, there was no description of expectations regarding roles of Facility staff (e.g., assessing potential community options, providing training to staff) or of potential transition activities, such as visits to potential homes, provider staff visiting Facility, etc. • The policy did not mention the Settlement Agreement requirement that action be taken prior to the individual's move if pre-move supports are not in place. • The policy did not address the quality of CLDPs. The policy listed two reviews of CLDPs to be undertaken, one at the Facility and one at State Office, but there were no requirements for any actions to be taken if needed improvements were identified. • There was no mention of need for the IDT to use the CLDP to ensure supports are in place. • There was no standard that the Facility exert its best efforts to address concerns identified through post-move monitoring. The policy did not, for example, specify any requirement for consideration of enhanced monitoring or follow-up in the event of identified issues or adverse occurrences.	

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		• The policy should draw from, and line up with, the metrics submitted by the Monitors and the content of the monitoring reports. As noted above, RGSC SOP ICF-IID 200 01 was revised in December 2013. It addresses some of the concerns the Monitoring Team has expressed about the DADS policy, such as requiring that pre-move supports be in place before the individual moves, and requiring each individual's ISP to develop strategies and action plan to overcome obstacles. However, it also does not address some issues, such as expectations regarding roles of Facility staff or of potential transition activities.	
	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. As has been reiterated since the baseline review, 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 Funding Issues related to citizenship	Noncompliance

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		status and one indicated the obstacle was LAR Choice. Plans to address these obstacles at the individual level were not adequate. Of the two sample ISPs reviewed, neither (0%) included an action plan to address/overcome obstacles identified that was adequate (i.e., individualized, measurable, and comprehensively addressed the obstacles). Examples included: • Individual #82 was not a US citizen and the barrier selected was Funding Issues related to citizenship status. The Individual had been on at least one CLOIP tour during this past year and had indicated an interest in community living, either with family or in a group home. The IDT developed an Action Plan to have the LA and the QIDP contact the family to begin the citizenship application process and for the QIDP to undertake some research to determine what other actions might be available. These were to occur at least one time within two weeks of the ISP date and then "as needed." The IDT explained the situation to the individual, who was reported to have understood why community living was not an option at this time. The IDT further agreed to suspend participation in CLOIP tours until citizenship could be obtained. Given the individual's apparent capacity to understand the nuances of HCS funding, it was not clear why community living awareness and education could not continue to be fostered. It was also not clearly articulated whether there was any possibility of living with family, which would not require group home funding. On a positive note, as reported in Provision U2, the HRO reported she and two QIDPs are investigating the naturalization process and will present information to the Guardianship Committee. • The QIDP facilitated a thoughtful interdisciplinary discussion about the potential benefits of community living for Individual #94, but the IDT did not adequately address obstacles to community living. The obstacle identified was LAR Choice and the IDT developed Action Plans to provide information to the LAR, invite the LAR to tour homes in the area and invite the LAR to a provider fair. While these could be components of an appropriate plan, none of these addressed the reason for the LAR's choice, which was documented as concern about the individual's challenging behaviors. The IDT should have identified the specific nature of these concerns and then developed Action Plans that were pertinent. This might have included, for example, identification of homes to tour that had staff with particular training in behavior support and/or a plan to ensure the Behavior Support Plan addressed these specific concerns as measurable outcomes that would allow the IDT and LAR to track progress toward resolving that barrier. In addition, the individual had not had an individualized awareness and education plan the previous year. The IDT developed an Action Plan to obtain the LAR's consent for participation in community tours, but did not identify any specific plan for implementation that included attention to the individual's preferences or learning needs.	

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		Preferences of Individuals and LARs 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).	
	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: The Facility did not yet succeed in developing individualized and measurable plans for community education and awareness. 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%) sample 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. For example, the IDT determined that community tours should be provided for Individual #94, but the Action Plan gave no information of how many tours would be planned, what kinds of residential and day program providers would be toured, or what responses of the individual to record. Of 10 "ISPs Addressing Living Options" provided by the Facility, eight (80%) did not include a completed section on the living options. Zero (0%) provided an Action Plan for education. For Individual #62, there was an extensive discussion of issues related to the living options, including that the LAR wanted the individual to remain at RGSC at this time. For Individual #103, who had been admitted recently, there was no action plan for education about community living opportunities. An annual provider fair The Facility held a Provider Fair on 3/26/14. Training/Course Sign-In Sheets documented participation by six provider agencies, the Local Authority (LA), 36 individuals (54% of population at the time), 30 staff, and two families. This was the third Provider Fair held in less than a year. 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. Regular SSLC meeting with the Local Authority (LA): The Facility provided documentation of attendance at a Tropical Texas and HCS/Txhml	Noncompliance

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		Provider Agency Meeting that involved multiple agencies. The Facility did not provide documentation of regular meetings with the LA to review issues specific to movement of individuals from RGSC. <u>Education about community options</u> RGSC did not have a consistent or formalized plan for collecting data on specific outcomes or measures related to education about community living, nor for using such information to evaluate opportunities to improve outcomes. Examples included: • IDT Action Plans: RGSC was not yet collecting data regarding the development and implementation of ISP Action Plans for community awareness and education in order to ensure these receive sufficient priority by IDTs. It should develop a process to do so. • Provider Fair: Although RGSC collected information about the number of attendees, it did not collect data on outcomes or measures of the effect of attendance. RGSC did have a process to collect information about responses of individuals to tours of community providers, as reported below. As indicated in previous reports, the annual LA CLOIP process continued to comprise a significant portion of the Facility's overall plan for education and awareness for individuals. The Monitoring Team reviewed the CLOIP documents for Individuals #5, #11, #29, #51, #62, #79, #97. #101, #103, and #114. • The LA met or had telephone conversation with a primary correspondent or LAR for six individuals (60%). This was a significant increase since the last visit. • The LA met with seven individuals (70%). The LAR for one individual requested the CLOIP information not be presented to the individual. • Of the seven individuals, four (57%) responded and expressed preferences or were otherwise responsive. The LA was present at both annual ISP planning meetings observed by the Monitoring Team. <u>Tours of community providers</u> The Facility continued to work towards a consistent, formalized process to fashion provider tours as a part of an individualized community living awareness and education plan. • <u>Opportunities to go on a tour available to all (except those individuals and/or their LARs who state that they do not want to participate in tours):</u> The Facility provided a table of tour surveys with dates from 10/16/13 to 5/16/14 that	

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		listed: o Individuals with dates of tours and provider agency toured o A summary of the individual's reactions to the visit o What the individual was able to tell about the visit or, if non-verbal, a description of expressions o A judgment of whether the individual enjoyed the visit o Whether there are any obstacles to the individual transition This table listed 33 tours by individuals. Many of the tours went to both a residence and a day program site. A total of 13 individuals (approximately 20% of the population) toured, with a range of one to six tours each. The Facility provided copies of invitations sent to correspondents, families, and LARs of nine individuals to encourage them to join the individuals at each of the tours. The Self-Assessment reported that 22 individuals participated in a community tour of alternate living environments during the past six months, that one family participated in a tour, and that 18 facility staff participated from 11/2013 through 4/10/14. There is no indication whether the table did not include all tours, or of any other reason for the discrepancy in numbers of individuals participating. • Size of tours: The number of individuals attending a single tour may have a significant impact on the learning experience for the participants, as well as the ability of staff to gauge individuals' reactions and respond appropriately to facilitate learning. The size of tours at the Facility appeared to be conducive to both individual learning and assessment of responses, averaging about two individuals participating in any given tour. Tours involved from one to six individuals, with eight tours of the eleven listed involving one or two individuals, a good size to permit interaction. • Places chosen to visit are based on individual's specific preferences, needs, etc.: An individualized education and awareness plan should define the types of settings to which an individual may need exposure to facilitate his or her understanding of community living options. The Facility did not report having a consistent or formalized process described for choosing tour sites based on individual preferences and needs. • Individual's response to tours assessed: A careful and thoughtful assessment of an individual's reactions to a community tour is necessary to an understanding of personal preferences, as well as to further guide the IDT in the development of an individualized community awareness plan and of a vision for living in the	

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		most integrated setting. The information from the table should be useful for planning by the IDT. <u>Opportunities are provided to visit friends who live in the community:</u> The Facility did not report visits to visit friends who live in the community. The Self-Advocacy training provided in conjunction with a community provider (reported in ;) provided opportunity for a few individuals to meet periodically with individuals who live in the community. <u>Education activities are provided for individuals</u> As reported above, the Facility provided documentation of a video shown during the 5/13/14 Self-Advocacy meeting about group homes. The Facility reported this showed an individual who had a successful move. The attendance sheet listed 23 individuals who attended and provided comments about six of those individuals who indicated interest in group homes. The Facility also provided a handout used in training provided by the LA (Tropical Texas) about the CLOIP process and reported that 25 individuals viewed a CLOIP video; the Facility provided sign-in sheets for staff who attended sessions in April and May 2014. The Facility reported three families also attended these sessions. The Facility did not report other educational activities for individuals during house meetings for individuals, during family association meetings, or during other appropriate situations or locations. <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 covered the CLOIP process and information provided to individuals about their rights regarding community living. Direct Support Professionals (DSPs) accompanied individuals on each community tour. This is an excellent way to provide information and to permit DSPs to get answers to their questions and concerns, and to see what supports individuals will need when they move to a more integrated setting. As reported above, 30 staff attended the Community Provider Fair. <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.	

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		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.	The Facility was implementing the State Office's process to have each professional member of the IDT document his/her recommendation regarding the individual's ability to transition to the community in the assessments completed prior to annual ISP meetings. In addition, at the ISP meeting, the professional members of the team were expected to make a recommendation to the individual/guardian. The most recent format of the ISP included a section that more specifically addressed teams' recommendations regarding transition to the community. <u>Percentage of Individuals Assessed as Required:</u> Of two ISPs reviewed for Individuals #82 and #94: • Nine of 14 (64%) assessments made a statement as required. • Of the 14 assessments reviewed that did offer a recommendation, three (21%) included substantive and individualized recommendations for how the individual's needs could be met in a more integrated setting. In most instances, 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. The Facility provided "ISPs Addressing Living Options." The Monitoring Team reviewed these for Individuals #5, #11, #29, #51, #62, #79, #97. #101, #103, and #114. Zero of 10 (0%) documented recommendations from all professional disciplines. For Individuals #62, #101, and #103, no recommendations from any discipline were documented. For the remainder, either four or five professionals made recommendations. Only the speech clinician was documented as making recommendations on each of the seven for whom recommendations were documented. These findings are puzzling. In reviewing a separate sample of OT/PT assessments, the Monitoring Team found that 10 of 10 assessments (100%) included such a determination, whereas only six of 10 (60%) of the ISPs provided by the Facility included a determination by OT/PT. Three of 10 (30%) ISPs documented a decision by the IDT as a whole. One of those three (33%) recommended movement; two of three (67%) determined movement was not appropriate at this time. It should be noted that one individual for whom there was no documented decision had transitioned since the ISP meeting. As described in Provision T1b1, the IDTs continued to lack proficiency in identifying	Noncompliance

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		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 community living discharge plan in a timely manner. Such a plan shall:	Since the last compliance visit, two individuals had transitioned to a more integrated setting. <u>Timeliness of Development and Implementation of CLDP:</u> The CLDP was to be initiated at the time of referral and was to be updated on an ongoing basis as circumstances required. The Monitoring Team reviewed a sample of four CLDPs (for Individuals #72, #115, #133 and #134) in progress for referrals made during the past six months. • State policy 018.2 required the IDT to meet within 14 days following the referral date to discuss a series of topics. Documentation provided by the Facility indicated this generally occurred. The Profile sections of the CLDP, which document most of this information, were partially but not entirely complete for all of the four reviewed. • The Monitoring Team requested evidence to show that the CLDPs in progress were being updated throughout the transition planning process. None of four (100%) CLDPs in progress provided included such evidence. The Monitoring Team also reviewed two completed CLDPs. • Two of two (100%) included documentation that indicated there was ongoing activity implemented. <u>Development of CLDP in coordination with the LA:</u> A review of a sample of two completed CLDPs (for Individuals #101and #149) indicated that two of two (100%) CLDPs included documentation to show that the Facility worked collaboratively with the LA, including participation in CLDP meetings. However, it was not clear whether the LA had completed the Continuity of Care-Move Site Review Instruments for the Community Living Discharge Plan as further described in Provision T1e below.	Noncompliance
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community	<u>Actions to be taken by the Facility Specified:</u> Two completed CLDPs were reviewed to assess whether they clearly identified a comprehensive set of specific steps that Facility staff would take to ensure a smooth and safe transition by including documentation to show that all of the activities listed in the below six bullets occurred adequately and thoroughly. • Training of community provider staff, including staff to be trained and level of training required.	Noncompliance

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	living discharge plan with provider staff.	• Collaboration with community clinicians (e.g., psychologists, PCP, SLP). • Assessment of settings by SSLC clinicians (e.g., OT/PT). • Collaboration between provider day and residential staff is ensured • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community) • Collaboration between Post-Move Monitor and Local Authority staff Neither of two CLDPs reviewed (0%) did clearly identify a comprehensive set of activities to occur on the day of the move and the responsible staff member, although the CLDP for Individual #149 was more complete than that for Individual #101. • Collaboration with community clinicians: One positive finding noted was some level of emphasis on collaboration between community providers and RGSC providers, including specific requirements for the physician to communicate with the designated community physician to ensure understanding of health care concerns and any specific actions that should occur quickly. The Facility had assigned the Nurse Case Managers responsibility for Continuity of Care and had provided a training session in April 2014. • Training of community provider staff: Issues of concern found in review of these activities included the following related to training of community provider staff: o For one of two (50%), there was sufficient documentation of training of provider staff, visits by the individual to the provider sites and the individual's responses and provider staff attendance at the CLDP. o One of two (50%) CLDPs included some documentation that specified the level of training that would be provided to community provider staff or the competency to be achieved by those trained.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	<u>Responsible staff identified for needed actions:</u> For two of two (100%) completed CLDPs reviewed, the Facility consistently identified the Facility staff responsible for each of the essential and non-essential supports by name. It was clear which Facility staff had been assigned responsibility to monitor and/or follow up with the designated provider staff to ensure implementation and/or timeliness for each and every support. <u>Completion timeframes for needed actions identified:</u> For two of two (100%) completed CLDPs reviewed, the Facility did consistently identify timeframes for completion for each of the essential and non-essential supports. Conclusion: This provision was found to be in substantial compliance.	Substantial Compliance
	3. Be reviewed with the	<u>Evidence of individual/LAR participation:</u>	Substantial

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	individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Based on review of two completed CLDPs, two (100%) included documentation that the plans had been reviewed with the individual and/or the LAR as evidenced by signatures on the CLDP and/or narrative descriptions in the summary of transition activities found in the CLDP document. Conclusion: This provision was found to be in substantial compliance.	Compliance
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 Discharge Assessment Checklists for Individuals #60 (who was scheduled to move the week following this visit), #101, and #149. These listed the required assessments, the date received, and the date of the report. In addition, the Monitoring Team reviewed the assessments for the CLDPs for Individuals #101 and #149, who had transitioned. According to the Discharge Assessment Checklists: • For Individual #60, nine of nine applicable assessments (100%) were received within 45 days prior to the expected transition date. The Social/QIDP assessment did not list a "Date of Report" so it could not be determined when that was completed. "Residential" was noted "NA." • For Individual #101, 10 of 10 assessments were received within 45 days prior to the transition. The Residential/Functional Skills Assessment Date of Report was dated more than six months prior to the transition, meaning that 9 of 10 (90%) were completed within 45 days prior to transition. • For Individual #149, nine of nine applicable assessments (100%) were received within 45 days prior to the expected transition. "Residential" was noted "NA." Based on the Monitoring Team's review of the assessments, assessments for Individuals #101 and #149 appeared to have been completed within the required timeframe. <u>Adequacy and Comprehensiveness of Assessments:</u> In order to be considered a current and comprehensive assessment of needs and supports, the findings and recommendations must be accurate and reflect all significant information the IDT and the community provider would need to develop an appropriate transition plan. Assessments were still not being consistently well integrated into a comprehensive assessment in a manner that allowed for the CLDP to adequately reflect the needs and supports to be provided in the community setting. As described in Provision T1e below, in a review of two completed CLDPs, the Monitoring Team found that the assessments did not consistently address the full array of services and supports needed for each an individual to make a successful transition, nor how the individual's preferences could be accommodated and supported in a community setting. In addition,	Noncompliance

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		many assessments reviewed did not place any emphasis on recommendations and strategies for community integration and how the individual could be supported to take advantage of the new opportunities community living might offer. The Monitoring Team found that there continued to be discrepancies and/or omissions in assessments that were either not addressed or not resolved that found their way into the final CLDP, and recommendations within assessments that were not addressed. For example: • For Individual #101, the CLDP was held on 4/22/14. The ISP, which was also provided for review, had been held on 1/14/14. There were significant health-related issues raised in the ISP and the IRRF that were not clearly delineated, or were even not referenced, in the CLDP assessments. For example, the individual's risk level in the Gastrointestinal (GI) category was rated as high. Neither the medical Discharge Summary and Annual Update nor the Habilitation Therapies assessment provided as CLDP assessments adequately addressed the issues raised in the ISP. According to the IRRF, the individual had been recently diagnosed with multiple GI issues including gastritis and Barrett's esophagitis. o The consulting specialist recommended that anti-reflux measures be started. One of the measures the IDT agreed to was to obtain a hospital bed; once obtained, Habilitation Therapy would assess the head of bed elevation needed. These were included as Action Plans in the ISP. There was no reference to the need for the hospital bed or other specific anti-reflux precautions in the CLDP or in either of the medical Discharge Summary and Annual Update and Habilitation Therapy assessment. No Nursing Assessment for the CLDP was found. o The consulting specialist also recommended he follow the individual closely, to which the IDT agreed, according to the IRRF. This was not referenced in the medical Discharge Summary and Annual Update, nor included in the CLDP medical recommendations. o The issue of colon polyps was not well delineated in the CLDP. Depending on the type of colon polyp identified, more frequent screening colonoscopy maybe required. In addition, a diagnosis of internal hemorrhoids was not well delineated. This may be a sources of the individual's known anemia, and could cause pain and discomfort; possibly resulting in behavioral issues. o The Individual had a diagnosis of QT prolongation, a cardiac conduction abnormality that can lead to a fatal cardiac arrhythmia, which can be caused or exacerbated by certain medications, These include Lexapro, and Zyprexa, which the individual was prescribed. At a minimum, the ISP, and CLDP should include documentation that the consulting cardiologist, psychiatrist, primary care physician, and the LAR "are in	

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		agreement that the benefits of continuing an Individual with known QT prolongation, and prescribed medications that are known to cause or exacerbate QT prolongation outweighs the potential adverse drug effects, including possible fatal arrhythmia" . The Monitoring Team is concerned that the issue of known QT prolongation, in addition to episodes of known bradycardia, and other electrophysiological conditions were not clearly delineated in the CLDP, and that specific monitoring, and reporting parameters were not developed for this clinical issue. Furthermore, frequent monitoring for QT prolongation, especially before and adding other medications, including certain antibiotics should be considered in such cases. • There were discrepancies in the medical diagnoses listed in the CLDP for both Individuals #101 and #149. As reported in Provision L1, the medical diagnosis for Individual #149 listed on the physical description section of the CLDP, dated 3/27/2014, did not list a diagnosis of hypothyroidism, under the subsection of medical diagnosis; however, the active problem list under section III of the CLDP stated hypothyroidism as a diagnosis. In addition, Individual #101 had a recent diagnosis of diverticulosis by colonoscopy, which was not included in the body of the CLDP under medical diagnoses or Active Problem List, despite being found in the Discharge Summary and Annual Update. These discrepancies could lead to miscommunication of the individuals' health care issues. This provision was not in compliance. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: Expand upon the initiative to ensure the CLDP provides an accurate and complete description of each individual's needs for services, protections and supports. This could include an interdisciplinary review of the CLDP assessments prior to the final CLDP meeting to ensure all important information is adequately captured, discrepancies are identified and resolved and supports are described in an integrated manner. As a side benefit, this process would also be valuable for each team toward enhancing its interdisciplinary skills overall.	
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	<u>Identification of Pre and Post Move Supports:</u> In neither of the two (0%) completed CLDPs reviewed was there identified a comprehensive set of pre and post move supports, in measurable/observable terms, to be implemented. This finding was based on an evaluation of presence or absence of each of the following criteria: • A comprehensive and inclusive list of supports was provided and included each of these components:	Noncompliance

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	be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	○ Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. ○ All safety, medical, healthcare, risk, and supervision needs were addressed. ○ What was important to the individual was captured in the list of Pre and Post Move supports. ○ The list of supports thoroughly addressed the individual's need/desire for employment. ○ Positive reinforcement, incentives, and/or other motivating components to an individual's success were included in the list of Pre and Post Move supports. ○ There were Pre and Post Move supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. ○ There were Pre and Post Move supports for the provider's implementation of supports. That is, the important components of the BSP, PNMP, dining plan, medical procedures, and communication programming that would be required for community provider staff to do every day. ○ Topics included in training had a corresponding Pre and Post Move support for implementation. • The wording of every Pre and Post Move support was in appropriate, measurable, and observable terms. • Every Pre- and Post-Move support included an adequate description of what the Post Move Monitor should look for when doing PMM (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur. • Any important support identified in the assessments or during the CLDP meetings that was not included in the list of Pre and Post Move supports has a rationale as to why it was not included. Examples of deficiencies as to the above criteria in the CLDPs reviewed included: • As detailed in Provision T1d, for Individual #101, safety, medical, healthcare and risk needs were not adequately addressed in the CLDP assessments. As a result, important supports were not identified. For example, the anti-reflux precaution of the hospital bed was not included as a support nor was any rationale provided for its omission. Likewise, there was no support identified for follow-up with a GI specialist. Other deficiencies noted related to Individual #101 included: ○ The ISP indicated that while on a trial visit to another potential provider, Individual #101 had attempted to open cabinets and drink liquid soap. It also appeared to indicate there was some history of	

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		attempting to drink soaps and eat toothpaste, to the extent the ISP noted the IDT discussed whether a community home could be located that would have locked cabinets. No support was identified to ensure staff for the selected provider had adequate awareness of this potential danger. o Given a known history of H. pylori, GERD, hiatal hernia, and Barrett's esophagitis, the CLDP should have been very clear on the required supports and services for these conditions. Close follow-up with a gastroenterologist should be well considered at least annually; specific monitoring and reporting parameters should have been developed to assess for possible exacerbation of esophagitis, such as monitoring for pain, discomfort, and anorexia and blood loss. Furthermore, H. pylori can be refractory to the initial treatment, and consideration for follow-up testing should be considered, especially in a group home type setting. o Individual #101 had five reported falls during the year preceding the 1/14/14 ISP, including an emergency room visit for a CT related to a head injury. The IDT concluded the fall risk was low because the falls were not accidental but rather related to challenging behaviors. The only support identified by the facility in the ISP was to ensure the individual wore curly shoelaces. Falls were not addressed in the CLDP; while it was unclear the curly shoelaces were a sufficient response to minimize the fall risk, even this was not included a support in the CLDP. Given the individuals known clinical concerns of prolonged QT interval, and episodes of bradycardia, cardiac conditions, as well as other potential issues; such as potential adverse drug effects, orthostatic hypotension. There was no evidence that these issues were discussed by the IDT, and there was no effective plan, which would include specific clinical monitoring and reporting parameters for risks associated with falls. o Habilitation Therapy recommended a grab bar in the shower to assist the individual with transfers. This was not translated to a support in the list of Pre and Post Move Supports, nor was any rationale provided for its omission. o What was important to the individual was not captured in the list of Pre and Post Move supports. In the ISP, the IDT had identified several preferences and developed supports to ensure the individual had opportunities to enjoy these. They were not included in any Pre or Post Move Supports. The section of the CLDP entitled "Outcomes important to the individual and related personal goals" was left blank. • As reported in Provision L1, Individual #149 was prescribed calcium supplements, and the CLDP did not comment on the need to administer this	

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		medication at a separate time as the levothyroxine is administered. The manufacturer of the levothyroxine recommends a four-hour window between dosing levothyroxine and calcium supplements. There was no essential support listed to administer levothyroxine 30 minutes prior to eating or taking other medications prior to the first meal, upon awakening, or to train provider staff on the individual's medication administration requirements. • For Individual #149, it was documented that the individual was a hard worker who enjoyed employment. There were no specific supports identified related to either employment or day habilitation. This was also true for Individual #101. Although it could be gleaned from the Community Living Data section that day habilitation providers had been identified, this was not listed as a post move support, nor were there pre move supports identified for training day program staff. • For none of two (0%) CLDPs reviewed were there sufficient descriptions or adequately defined criteria of what the Post-Move Monitor should look for. There was minimal description of the evidence was required to demonstrate a support was adequately in place. Observation and staff interview were frequently listed as evidence, but it was seldom specified what the observation or staff interview should reveal. Sometimes this appeared to be self-evident, but in many cases it was not. This is important because the Post-Move Monitor cannot be expected to have expertise in every area; the expertise of the IDT must be tapped to explicitly define what should be observed and what staff should be able to explain about the supports to be provided. For example, as reported in Provision L1, given that Individual #149 was on a weight management diet, a specific weight range should have been identified, and PMM staff should determine whether the provider assesses weight and reports changes based on an appropriate schedule identified in the CLDP. Also, because this Individual had criteria for bradycardia, at a minimum specific monitoring and reporting parameters should have been developed for monitoring by the provider agency. The CLDP should ensure that specific monitoring parameters are developed for necessary clinical monitoring to provide guidance for the post move monitoring assessment. <u>Pre-Move Site Visit Completed by Facility</u>: The Post-Move Monitor was reported to be generally responsible for completion the Pre-Move Site Visits reviewed. No such visits were conducted during the monitoring visit, so the Monitoring Team was not able to observe the process but rather relied upon documentation to assess compliance. The Monitoring Team reviewed the Pre-Move Site Review documentation completed for two individuals who had transitioned in the past six months. For the two individuals, a Pre-Move Site Review was conducted by the Facility for two (100%).	

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		• Two of two (100%) were completed on a timely basis. • One of two (50%) included a visit to each service provision site. For Individual #149, the pre-move site visit review documented a visit only to the group home; this was because a contract with a day habilitation site had not yet been finalized. • The Monitoring Team also reviewed the Pre-Move Site Visits for any testing of staff knowledge of individual's needs for supports, services and protections prior to the move. Neither (0%) called for staff interviews related to any supports; only observations of the completed in-service materials and signature sheets were requested. <u>LA Continuity of Care Process</u>: No LA Continuity of Care Pre-Move Site Review Instruments were provided for review. <u>Coordination of CLDP with provider staff:</u> A review of completed CLDPs indicated provider staff were typically involved throughout the CLDP process. In two of two (100%), there was documentation visits by the individual to the provider sites and the individual's responses, and provider staff attendance at the CLDP. For Individual #149, the Facility also provided specific documentation of provider staff training and competency-testing. <u>Conclusion:</u> This provision was found to be not in compliance.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	In the Provision Action Information, the Facility reported, "No changes in this provision." 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. RGSC SOP ICF-IID 200 01 does have a section on quality assurance. This requires the APC and Community Placement Specialist to review the CLDP prior to submission to the ICF-IID Program Director for approval and to the DADS Continuity of Services Coordinator within seven calendar days after the transition. DADS State Office staff are then to review a sample of CLDPs and identify trends and areas in need of improvement. The Facility had implemented the Discharge Assessment Checklist, which provided the APC with a tool to track assessments and take action as needed to ensure timely assessments. The Facility did not provide data and/or reports to permit the Monitoring Team to determine whether data were collected consistently.	Noncompliance

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		The Facility did not provide CLDP monitoring tools. The Self-Assessment reported on monitoring tools but consistently indicated "0 of 0 (0%)" for each item to be reported from those tools. This likely was due to the Self-Assessment for Section T being completed before either of the two individuals transitioned; nonetheless, the Facility did not update the information and provide it to the Monitoring Team. Furthermore, the Self-Assessments stated "0 of 0 (0%) CLDPs held within the last six months were monitored by the QA Department/designee." CLDPs had been in process of development during that time.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	<u>Facility Annual Obstacles Report:</u> The Facility provided an updated report--Fiscal Year 2013 Obstacles to Community Transition. The report noted that LAR reluctance continued to be the greatest obstacle to referral for community transition at RGSC and the most difficult one to overcome. Strategies to overcome this reluctance included invitation to the provider fairs, provision of CLOIP information, education regarding the community transition process and about community services, and having community providers present information about their programs at the Parents Association. The second most frequent obstacle related to behavioral health and psychiatric support needs. The strategies to address this included continuing current supports to address challenging behavior and recommending that community providers obtain training. These strategies have not been effective to date. The Facility must work with DADS to develop strategies that the Facility alone cannot put into place. The report also addressed obstacles to transition following referral. The two most frequent issues reported were Individual/LAR indecision about provider selection and transition, and delay in transition due to the provider opening a new home for the individuals. <u>Annual Narrative by DADS State Office</u> The State did not present an annual narrative that showed it had: a) conducted an analysis of the Facilities' data; b) taken 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; and c) as appropriate, DADS made efforts to seek assistance from other agencies or the legislature.	Noncompliance

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		DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/13 from all 13 Facilities. The report was issued to the Monitors and DOJ on 3/27/14, seven months after the data collection period ended. The following summarizes some positive aspects of the report: ▪ The statewide report listed the six obstacles to referral categories and 12 obstacles to transition categories used in FY13. ▪ DADS included a list of 14 initiatives it was continuing to support. ▪ The report included attachments with each of the Facilities' annual reports. ▪ The validity of the obstacles to referral data appeared to be more accurate than in previous years' reports. However, as noted in the Monitoring Teams' reports, concerns still existed with teams' accurate identification of obstacles. The following concerns were noted with regard to the report: • <u>Transition Data:</u> In the report, the State Office provided overall data related to transition of individuals from SSLCs, and the overall census from fiscal year to fiscal year. However, the data was fairly meaningless, because the data was not broken down sufficiently or analyzed. For example, although Facility censuses had decreased over the years, data was missing and no analysis was provided regarding how many individuals had died, how many admissions occurred, the numbers of individuals that died shortly after transition to the community, the numbers of individuals transferred to other large facilities, etc. • <u>Transition obstacles data</u>: Adequate methodologies were not described as to how data regarding obstacles to transition were determined and collected. For example, it was not clear if one individual could have had more than one obstacle, and/or if different obstacles presented themselves at different times during the transition process. Further, the data should describe whether these obstacles to transition were overcome. As a result, the validity of the data provided in the report was questionable. Further, it would be useful to formalize the process to identify obstacles far ahead of the 180-day goal (i.e., not wait until 180 days have passed before identifying and documenting obstacles). o State Office staff reported during recent discussion with the Monitors, that anytime the IDT identified an obstacle to transition, it should be included into the database. Further, State Office staff said that their data system allowed for an individual to have more than one obstacle to transition and indeed many individuals did have more than one obstacle in the data. The data system, however, did not track, or report on, whether obstacles were successfully addressed (i.e., whether the individual had not yet moved and/or whether compromises had to be made). The Monitoring Team believes that this information should be included in the report.	

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		• DADS' strategies: DADS included a list of strategies and actions, however, they did not thoroughly address some of the most frequently cited obstacles that the Facilities had identified. For example, according to the 2013 Annual Obstacle Report Data spreadsheet, 353 individuals were not referred due to "Behavioral health/psychiatric needs requiring frequent monitoring...," 308 individuals were not referred due to "Medical needs requiring 24-hour nursing…," and 1698 individuals were not referred due to "LAR's reluctance for community placement" (almost 50% of the population of all of the Facilities). Most of the 14 strategies/actions described general activities, such as to improve the ISP process, the coordination of transition activities, data collection, or special projects at Austin SSLC. Although these appeared to be worthwhile activities, few strategies specifically addressed the above three categories: behavioral/psychiatric (strategies 7 and 8), medical-accessibility (strategies 9 and 10), and LAR preference (perhaps strategies 1 and 12b). Moreover, given that many of the strategies were repeated (or slightly modified) from last year's report, an update on the status of each would be appropriate to include in this report. o During recent discussion with State Office staff, the staff agreed that better overall analysis was needed in order to tie identified obstacles to their set of statewide strategies (and/or to ensure that there were strategies to address the most-often identified obstacles to referral and to transition). • Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). Both the Facility and DADS need to analyze the information in these reports, prioritize areas that could be effective in providing greater opportunities for movement, and propose actions and strategies to address those opportunities.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the	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.	Substantial Compliance

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	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.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a	To evaluate post-move monitoring, the Monitoring Team reviewed pre-move and post-move monitoring visit documentation for Individuals #101 and #149, who had moved since the last compliance visit, and visits during this review period for Individual #132, who had moved near the end of the last review period. This sample represented 100% of the individuals for whom post-move monitoring was required. <u>Staffing</u> Armando Cobos, Transition Specialist, conducted all five post-move monitoring visits. Alma Ortiz, Admission/Placement Coordinator, participated in conducting one post-move monitoring visits along with Mr. Cobos. Both also conducted the pre-move site reviews. <u>Timeliness of Post-Move Monitoring Visits</u>	Noncompliance

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	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.	Five of five (100%) required post-move monitoring visits were completed timely, including one completed during this compliance visit. These were two visits each for Individuals #132 (8-45 days and 46-90 days) and #149 (1-7 days and 8-45 days), and one visit for Individual #101 (1-7 days). Visits to All Sites The Facility continued to ensure that visits had been made to both the residential and day sites of the individuals, and that this was documented in the reports. For the 1-7 day visit for Individual #149, only the home was visited, as the individual had not yet begun to attend day habilitation. Use of Standard Assessment Tool All visits were documented on the statewide Post-Move Monitoring Checklist of December 2013. All components of each checklist were completed. Assessment of Presence of Supports Called for in CLDP: The Monitoring Team reviewed the PMM Checklists to evaluate the process for assessing the presence of supports as well as efforts undertaken by the Facility to ensure implementation of the supports. This review was based on the supports as identified in the CLDP. • The checklist describes what evidence the post-move monitor will review for each support and has a place to check that this was done. It does not require the monitor to state what s/he actually checked. If the evidence required were always clearly stated, this might not be a concern. However, this was not always the case. For example, for Individual #132, the evidence required for the support of "Continue on Calcium and Vitamin D supplements" was "Visual Observation." There was no indication whether the monitor was to observe the medications, a medication administration document, a prescription form, actual provision of the medication, or something else. For some supports, but not all, the monitor documented how s/he checked the support. Therefore, the Monitoring Team must assess this based on whether all supports were checked, and on whether any supports were noted as not present. • Each support was checked on each PMM checklist. The monitor noted on the checklist any supports that were not present or completed. The monitor also reported needs for follow up, changes in treatments and interventions, and any other significant issues under Post Move Monitor Follow-Up Activities. However, numerous appointments and clinical actions were noted as to be done, and there was no documentation (other than the checkmark) that the PMM had actually checked to ensure these had occurred. For example, for Individual #149, dates of dental and vision appointments were written on the checklist; these dates were prior to or shortly after the 1-7 day visit. Neither the 1-7 day	

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		visit checklist of 8-45 day visit checklist noted whether these appointments had occurred; it should be noted that the monitor did check this at the 8-45 day visit observed by the Monitoring Team but did not document it on the checklist. Another example for this individual was that the Facility psychiatrist was to document a discussion with a community psychiatrist; neither checklist reported that this occurred. The Facility should not rely simply on a checkmark to identify that a support was checked. At least one checklist should verify how it was checked and that it was completed. Similarly, for this individual, the 1-7 day visit checklist had the comment "Pending" regarding an annual gynecology appointment, which would not be due until more than six months after transition. The 8-45 day visit checklist stated the date that had been established for the gynecology appointment, which was before the date of this visit. There was no statement that the PMM had verified the appointment had occurred. • The PMM made a summary statement about the settings and provision of supports on five of five checklists (100%). <u>Facility's Efforts to Ensure Supports are Implemented:</u> The primary reasons for conducting post-move monitoring are to identify if the protections, supports or services that the individual requires are in place, and, if any issues are identified, to take action to correct them. The following summarizes the findings of the review of post-move monitoring documentation: • Zero of five PMM checklists indicated concerns that needed to be addressed. This was in spite of a few items that were found not in place. For example, during the 8-45 day visit for Individual #149, the monitor asked to see the individual's plate guard at both the home and the day habilitation site. It was available at the home but not at the day habilitation site. There was no statement of any follow-up the monitor would do prior to the next PMM visit. Each support not available should trigger an action and documentation that the support has been provided. If the concern requires an IDT meeting, there should be documentation of the outcome of the meeting. This provision was found in substantial compliance at the last visit. At that time, most checklists had explanations of narrative for some of the items reviewed, and a follow-up action was described. Unfortunately, at this visit, documentation is not clear enough to verify that all required monitoring was done, and that appropriate follow-up occurred. Therefore, this provision is found in noncompliance. For the Facility to achieve substantial compliance again, documentation must be done of the actual reviews of supports and of follow-up actions.	
T2b	The Monitor may review the	The Monitoring Team accompanied the APC, the Transition Specialist, and Quality	Substantial

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	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.	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). In fact, although many of the supports listed on the checklist (taken from the CLDP) only required the monitor to check documentation, the monitor made sure to observe and interview staff. For example, the PMM is to monitor daily documentation by agency staff of aggressive behavior, he not only checked documentation but also asked a trainer at the day habilitation program, who was able to describe one instance and how staff intervened to redirect so that aggression did not occur. The PMM did check to make sure appointments had occurred as scheduled. The PMM not only observed to determine whether the staff communicated to the individual in simple conversations but also interviewed the staff to determine whether she was aware of the individual's communication patterns.	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.	This provision does/does not receive a rating.	Not Rated
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of	The Facility reported there were no alternate discharges.	Not Rated

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	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 5/7/14 2. RGSC Action Plans 5/7/14 3. Provision Action Information for Section U 4. DADS Policy 019 Guardianship 3/7/12 5. Statement "No new policy nor major revisions to current policy Reviewing the Need for Guardianship ICF-IID 200 04" 6. RGSC SOP ICF-IID 200 09 Self Advocacy Program—the "Rough Riders" March 2014 7. Determining the Need for Guardian vs. Advocate—guidelines 3/14 8. Prioritized list of individuals lacking both functional capacity to render a decision and a LAR to render such a decision 9. List of individuals who have renewed guardianship or have established advocates 10. Statement "Currently no instruments used to determine functional capacity" 11. Rights Assessments for Individuals #82 and #94 12. Guardianship Committee minutes of 12/13/13, 1/30/14, 2/27/14, and 3/20/14 13. Self-Advocacy Meeting Presentation of Video on Group Homes & Nomination of Officers Sign-in Sheet 5/13/14 14. Minutes of Self-Advocacy Group Meetings of 11/20/13, 12/17/13, 1/21/14, 1/27/14, 2/1/14, 2/26/14, 3/20/14, and 3/26/14 15. Draft Capacity to Give Informed Consent Assessment **People Interviewed:** 1. Vanessa Alvarez, Human Rights Officer (HRO) **Meeting Attended/Observations:** 1. ISP Annual Planning Meetings for Individuals #126 and #140
	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 (31) of individuals reviewed for guardianship during annual staffings from 11/5/13 through 4/8/14 o Number of individuals out of 31 reviewed who had a guardian, had an expired guardianship, had a potential guardianship resource, were pending guardianship papers, had an advocate, had potential advocate resources, or had not resources for guardianship

	or advocate o Numbers of individuals at each priority level on the Need for Guardianship or Need for Advocate list, or who are in the process of obtaining a guardian, as of 4/11/14 through 4/14/14 o The number of individuals who have a guardian as of 4/11/14 through 4/14/14 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 Although there was no measurement of the quality of review of the need for guardianship, 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 Monitoring Team concurred. 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 identified two areas of need/improvement. For Provision U1, this was that "all individuals' capacity has not yet been formally assessed or determined." While this is true, it results from the lack of a structured process to assess capacity for decision-making. For Provision U2, the Facility identified that a significant percentage of individuals have a need for a legal guardian or advocate according to the prioritized ratings of need for a guardian or advocate. • The actions did provide a set of steps likely to lead to compliance with the requirements of this Section. For example, the Facility had adapted a capacity assessment tool and had two further steps planned—begin use (which was in process) and provide training on the newly revised Rights Assessment with emphasis on identifying capacity (which would integrate the information from the tool into the rights assessment process). For increasing appointment of guardians and advocates when needed, the Facility had actions to address several aspects, including reminding guardians of need for renewal and working with Texas Rio Grande Legal Aide to minimize cost of guardianship.

	Summary of Monitor's Assessment: RGSC continued to make significant efforts to meet all requirements of this provision, including drafting a process for assessing capacity of individuals to make decisions, considering advocates as an alternative to guardianship, and finding means to assist with the financial burden of applying for guardianship. Achieving compliance is dependent on implementation and effective, individualized use of a capacity assessment process and on effect of process to obtain guardians and advocates. **Provision U1:** The Facility had been making efforts for over six months to develop a tool and process for assessing capacity to make decisions and integrating that into both the determination of need for guardianship or advocate and the rights assessment. The Facility presented an action plan to begin implementation of this process. Observations made by the Monitoring Team of the ISP meetings held during the site visit indicated that IDTs did not undertake any substantive discussion regarding decision-making capacity or strategies to enhance participation in decision-making as they pertained to the ability to provide informed consent. The Facility maintained a prioritized list of individuals who did not have a current guardianship and were in need of a guardian or advocate; this was updated semiannually. **Provision U2:** The Facility had made some progress in advancing or continuing processes to obtain LARs or advocates for individuals who needed assistance in making decisions. Actions included establishing a relationship with Texas Rio Grande Legal Aide to assist potential legally authorized representatives (LARs) to apply for guardianship and providing advocacy training for families of individuals. There remained a need to obtain more guardians and advocates; the Facility needs to continue and to expand on its current efforts, with an expanded focus on recruiting new LARs and advocates in addition to renewing guardianships as they expire.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision 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	Policies And Procedures Related To Functional Capacity To Give Consent And/Nor Need For LAR: No new DADS policies had been issued related to this provision. DADS Policy 019: Guardianship, effective 3/7/2012, addressed the development and maintenance of a prioritized guardianship list as required. The Monitoring Team had expressed concern in previous reports that the policy, while requiring IDTs to make an assessment of an individual's decisional capacities, provided little to no guidance as to how this assessment should be accomplished. The policy did not address the standardized process, methodology, or tools IDTs should use to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making. The Facility's IDTs continued to need guidance and training from DADS to prescribe a process for how an assessment should be accomplished to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. Additionally, guidance needed to be provided as to how, and how often, a need for guardianship should be periodically reviewed. In the past several reports, it	Noncompliance

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	health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	was noted that DADS State Office reportedly was developing a policy on consent to supplement the one it had issued on guardianship. This was essential, because until a process is implemented to estimate individuals' functional decision-making capacity, it is difficult to develop the prioritized list of individuals the Settlement Agreement requires. The Monitoring Team was aware that State Office had issued a draft Individual Rights Assessment that included questions related to an individual's capacity to make decisions; the Monitors had jointly provided comments to State Office on the draft. The Facility had been making efforts for over six months to develop a tool and process for assessing capacity to make decisions and integrating that into both the determination of need for guardianship or advocate and the rights assessment. The HRO provided the most recent draft assessment form, which had been adapted from an assessment form used by a private provider in the area. The form provided instructions for using the form, questions divided into categories (including mental status, personal safety, personal health awareness, general and psychotropic medication issues, dental procedures, behavior management plans, and release of information, and a place for comments. The sample form provided, which would be used for staff training, included examples of the types of additional questions that could be asked to get information from the individual, and Facility reports and data that might provide information for assessing some questions. The Facility's Action Plan stated this would be implemented; presumably, this would be done on a pilot basis, evaluated for reliability and usefulness, and revised as needed. <u>Maintenance of Prioritized List:</u> The Facility maintained a prioritized list of individuals who did not have a current guardianship and were in need of a guardian or advocate. • Prioritization Criteria: The Facility continued to use the same prioritization criteria as previously reported. These were consistent with DADS policy. In addition to the DADS and Facility criteria, the Facility provided a table "Determining the Need for Guardian vs. Advocate." This table "was created to prompt IDT to have a thorough discussion(.)" It included questions about the Behavior Support Plan, psychotropic medication, health status, IDD level, communication status, family contact, and availability of guardianship resources. In completing the rights assessment, the Facility used a Consumer Needs Assessment Form. This form included a set of questions relevant to the priority listing criteria and then required a decision on the individual's status—whether the individual has a guardian, is able to make informed decisions or advocate for him/herself, and whether a request "for an advocate is being made by the consumer, legal guardian, representative and/or family member." • Timeliness: Although the prioritized list was not dated, both the Self-Assessment and the Provision Action Information reported ratings had been	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>done 4/11/14 through 4/14/14. According to the Provision Action Information, the last time it had been done was in October 2013. The time in between re-prioritizations was six months, meeting this requirement of the provision.

The table below reports the numbers of individuals at the different priority levels for guardianship and advocate:
<table>
<tr><th>Level of Need</th><th>Priority I</th><th>Priority II</th><th>In Process for Guardianship</th><th>Priority III</th></tr>
<tr><td>Guardianship</td><td>7</td><td>3</td><td>3</td><td>NA</td></tr>
<tr><td>Advocate</td><td>4</td><td>13</td><td>NA</td><td>8</td></tr>
</table>
In addition, 29 individuals were listed as Non-Priority. Those were all individuals who had a guardian or advocate.

<u>Assessment of Functional Capacity to Render a Decision:</u>
RGSC indicated it did not yet have a standardized process, methodology, and/or tool to assess functional capacity. As reported above, the Facility had been working on a process to assess decision-making capacity.

The Monitoring Team reviewed the Rights Assessments for Individuals #82 and #94. Individual #82 did not have a Legally Authorized Representative (LAR), or guardian; Individual #94 did have a LAR. The areas of restriction were identical for both individuals, except that Individual #82 had a restriction for money management and Individual #94 did not. Both individuals were found unable to give consent for all areas—medical, programmatic, financial (although Individual #94 did not have restrictions on money management), restrictive/intrusive practices, media/photo, and release of records. For neither individual was this finding qualified to identify some aspects of these areas that the individual was able to consent to. There was no specific basis offered for this determination in the way of an individualized assessment of the individual's decision-making capacity. Thus, it was not clear whether the assessment of capacity to consent was individualized.

Observations made by the Monitoring Team of the ISP meetings held during the site visit indicated that for neither of two individuals (0%) did the IDT undertake any substantive discussion regarding decision-making capacity or strategies to enhance participation in decision-making as they pertained to the ability to provide informed consent.

This Provision was found to be not yet in compliance. The Facility did maintain a list of individuals who did not have a guardianship imposed, but the determination of need was</td><td></td></tr>
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		not predicated on any formal or standardized process or tool. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: DADS and the Facility will need to prescribe an assessment process, methodology, and/or tool rooted in objective evidence-based principles of decisional capacity, and further, require the IDTs receive sufficient training and oversight to ensure they implement the process thoughtfully and carefully.	
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.	The Facility had made some progress in advancing or continuing processes to obtain LARs or advocates for individuals who needed assistance in making decisions. Several actions were found to be positive, including: • Continuing to provide informal training on decision-making through a self-advocacy process that involved active participation of a large percentage of individuals who reside at the Facility and formal training through a collaborative relationship in which Arc of Texas provided self-advocacy training • Establishing a relationship with Texas Rio Grande Legal Aide to assist with guardianship application. The HRO reported two individuals currently are in process of establishing guardianship through this process, but the process takes six to nine months to complete. • For individuals seeking guardianship with assistance from Texas Rio Grande Legal Aid, the HRO reported providing advocate training for family members of the individuals. Minutes of Guardianship Committee meetings documented discussions by that committee of the characteristics needed of advocates and the need for such training. This training was, according to the HRO, also provided to a family that was seeking guardianship without financial assistance. • The HRO reported she and two QIDPs are investigating the naturalization process and will present information to the Guardianship Committee. • The HRO reported the Rights Assessment process will soon require a skill acquisition plan for any restriction. The Facility needs to continue and to expand on its current efforts, with an expanded focus on recruiting new LARs and advocates in addition to renewing guardianships as they expire. <u>Policies And Procedures Related To Obtaining LARs For Individuals In Need:</u> • DADS Policy 019: Guardianship, effective 3/7/2012, provided guidance and protocol as to obtaining LARs for individuals who may need one. The Facility reported there had been no changes to the statewide policy. A local policy, RGSC ICF-IID 200 04 Reviewing the Need for Guardianship, continued to guide this process.	Noncompliance

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		• DADS Policy 057: Self-Advocacy, dated 5/30/12, guided self-advocacy practices. RGSC SOP ICF-IID 200 09 Self Advocacy Program—The "Rough Riders" had been revised as reported below. <u>Facility Efforts to Obtain LARs:</u> The Facility reported that six individuals had guardianship renewed. Two individuals admitted since the last compliance visits had guardianship established prior to admission; these were due to expire before the compliance visit, and the Monitoring Team did not determine whether these had been renewed. No new guardianships had been established. As of the Need for Guardianship list of April 2014, 13 individuals were in need of guardianship of 67 individuals on the list (19%). An additional 25 individuals (37%) were identified as needing an advocate; of these, nine individuals were identified as non-citizens, and it was noted that non-citizens are not able to have a guardian. The remaining 29 individuals (43%) 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 guardian, so that individuals could participate in decision-making to the degree appropriate. Although there had not yet been implementation 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 was making efforts to obtain LARs. Steps taken included: • The Facility established a relationship with Texas Rio Grande Legal Aide to provide services that minimize or eliminate the cost to apply for guardianship and provided notice to potential guardians. • The HRO reported the Facility provides notice to LARs prior to expiration of guardianship. • The Facility had begun to explore the naturalization process to address individuals or potential guardians who are not citizens. Even with these diligent efforts, the Facility must be more effective at establishment of guardianship. The Monitoring Team agrees with the finding of the Self-Assessment that the percentage of individuals who continue to demonstrate a need for a guardian or advocate results in a finding of noncompliance. The Monitoring Team understands the difficulty of this, despite commendable efforts by the Facility, and the need for assistance from DADS and others to address these barriers.	

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		Guardianship Committee Minutes of Guardianship Committee documented meetings one or two times per month. Membership appeared to be consistent with statewide policy requirements. The Guardianship Committee reviewed both status of guardianship for specific individuals and systemic issues such as recruitment and development of training for advocates. The Guardianship Committee reviewed the proposed capacity assessment process and form, and suggested revisions to be made for more objective measurable criteria. The statewide policy also called for the HRO to maintain data, including a list of individuals without an LAR; names and priority levels of individuals referred to the Guardianship Committee; status of the referrals; and dates guardianships were secured. In addition, the Facility was to make monthly progress notes regarding the status of individuals referred to the Guardianship Committee. These data were not adequately reflected in the ongoing minutes and provided little follow-up information from one meeting to the next. The Guardianship Committee had reviewed only two individuals in the four months for which minutes were provided; there was no documentation of follow-up discussion for either. State Policy also calls for the Guardianship Coordinator to organize an annual guardianship in-service for individuals, families, staff and other interested parties to discuss guardianship, alternatives to guardianship, the benefits and disadvantages of guardianship, limitations to guardianship, types of guardianship, who can and cannot be a guardian, and other relevant topics. The Facility did not report such an in-service training, but did report advocacy training for three family members for two individuals. Self-Advocacy Activities The Monitoring Team commends the Facility for its extraordinarily active development of a self-advocacy program that involved a high percentage of individuals in regular self-advocacy meetings (reportedly over 70%) and a formal self-advocacy training for a smaller number of individuals, provided by Texas Arc and involving individuals served both by the Facility and by a private community provider agency. RGSC SOP ICF-IID 200 09 had been revised to include an officer called the "quality advisor" to assist members in completing satisfaction surveys, assist other officers in preparation of meetings, review minutes, and promote advocacy awareness. Another revision was the addition of one representative from each home to report on issues and concerns from the homes to officers and the Self-Advocacy Coordinator (the HRO). These revisions highlighted the evolution of the group from one directed by the HRO to one in which individuals had the opportunity to make decisions and to have	

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		responsibilities, with the assistance of the HRO. Minutes of the self-advocacy group meeting of 11/20/13 documented discussion of being able to advocate for one self during medical and dental visits. This included training on use of a pain scale, which was provided to each participant. Although no other meeting minutes described specific training on decision-making and advocating for one self, there were several topics for which decision-making by the group was encouraged (such as selecting a logo for T-shirts, scheduling the best time for meetings, and choosing healthful foods). The meeting records documented that information about abuse, neglect, and exploitation (including reporting) was discussed at eight of the eight meetings (100%). One other topic was the focus of each meeting. The topics documented in the meeting records for this period were advocating for one self during medical and dental visits, movie nights, scheduling self-advocacy group meetings, healthy eating, phone use, officer elections, and voting. The Facility provided a listing of 25 individuals who viewed a video on group homes provided by Arc of Texas. Comments were provided on reactions of several individuals. 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 5/7/14 2. RGSC Action Plans 5/7/14 3. Provision Action Information for Section V 4. Presentation Book for Section V, including (among other documents): a. Active Record and Individual Notebook Audit Tools b. Audit Tool Cheat Sheet c. RGSC Monthly Audit Findings d. Interrater Questions/Discussion Log e. ICF Monthly Deficiency Reports f. Examples of HIM Deficiencies Requiring Action and follow up emails 5. List of all new and revised State and Facility policies implemented since the last compliance visit 6. DADS Policy 020.1 Recordkeeping Practices 3/05/10 7. List of Policies and procedures Related to Record Keeping, Purging, Thinning, and Archiving: 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 4/3/14 including Audit Tool Cheat Sheets, Appendix D Guidelines Review, and sample Inter-Rater Questions/Discussions Log 8. RGSC SOP HR 100-07 Compliance with Required Training/Performance Evaluations/Corrective Action Plans/Health Information Management Deficiencies Requiring Action revised October 2013 9. RGSC SOP 400 19 Minimum Common Elements of Care 1/21/14, reviewed March 2014 10. RGSC SOP QM 100.011 Quality Assurance Plan/Program Narrative – ICF (4/14) 11. RGSC SOP QM 100.15 DADS Quality Assurance Expectations (4/14) 12. RGSC Policy Review table 13. Manual Mania and Survival Guide 14. Nursing meeting minutes from December 2013-April 2014 15. Table of Contents for Active Record and Individual "Me" Book 16. Record Audit Tools for last 10 audits conducted: February 2014 (Individuals #62, #97, #103, and #114) and March 2014 (Individuals #11, #29, #51, #66, #79, and #82) 17. Plans of correction resulting from record audits for the last 10 records audited 18. Plans of correction for systemic issues resulting from record audits 19. ICF Monthly Delinquency Reports to the Settlement Agreement-Program Improvement Committee (SA-PIC) for January, February, and March 2014

	20. FY 14 Section V Appendix D Compliance Report by Record 21. Active Record, Individual Notebook ("Me Book"), and Master Record for Individual #103 22. ISP Assessment Report (tracking log) November 2013 through March 2014 23. 2014 Assessment Report for reports due May 2014 as of the compliance visit (undated) 24. Assessments prepared for the admission ISP meeting for Individual #7 **People Interviewed:** 1. Leticia Gonzalez, RHIT, Health Information Management (HIM) Director, and Ruby Garcia, Unified Records Coordinator (URC) **Meeting Attended/Observations:** 1. ISP Annual Planning Meetings for Individuals #126 and #140 2. Admission ISP meeting for Individual #7 3. ISP Preparation meeting for Individual #85 4. Quarterly Psychiatric Review for Individual #51 5. Records storage areas at La Paloma and El Paisano
	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: ▪ An unspecified audit tool that provided information on compliance with Appendix D requirements. As the information came from the Facility's random audits, this tool most likely included the Individual Notebook Audit Tool-Vocational, the Individual Audit Tool-Residential, and the Active Record Audit Tool. o These monitoring/audit tools did not include 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. The Self-Assessment did not report use of the interview tool for use of information from the record; the Self-Assessment states the use of the Interview tool began in March 2014 after a hiatus during the vacancy of the URC position. 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 did not include adequate methodologies**.** Although the record audit tool provides an adequate methodology to review the presence of documents and compliance with Appendix D requirements, the Facility did not report any process to assess use of the records in making decisions.

	○ 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. ○ 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: Unified Record Coordinator, Outpatient HIM Supervisor, and HIM Director. ○ The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically/programmatically competent in the relevant area(s). ○ Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools. However, this was presented as an overall figure for the whole period, rather than monthly as done in the last Self-Assessment. Therefore, there is no indication whether the range of reliability findings indicates acceptable levels of agreement. • Used other relevant data sources and/or key indicators/outcome measures, but not for all requirements needing to be assessed. The Facility did report the number of policies revised. The Facility reported that at least five records audits were completed each month. The Facility did not report the percentage of deficiencies requiring action that were still not completed even though it accurately reported this to be the reason for noncompliance with Provision V3; this was reported in the Self-Assessment for the last visit. The Facility did report the percent of records not accessible at the time of the audit and not checked out properly; the Self-Assessment did not state whether this was determined through separate audits of the check out log or were done as part of the random records audits. • 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: ○ 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 not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in substantial compliance with Provisions V1 and V3. In both cases, there remains room for improvement, most particularly with timely completion of assessments. Nonetheless, the record is useful for decision-making and generally meets requirements of Appendix D; for example, over 90% of documents were present and current. Although there is a need for more timely correction of some deficiencies identified during audits, improvement in meeting Appendix D requirements indicates the audits have had an effect. 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. Many In Process items were actually items that will be ongoing, such as identifying need for change in policy development or revision, and "Present audit findings monthly at SA-PIC for analysis using CATW2." These ongoing processes can be identified but do not provide a plan for establishing and implementing means to achieve compliance, nor do they identify priorities for action. For example, the policy action does not indicate which policies required to implement the Settlement Agreement are targeted for development during the next six months. Presenting audit findings for action is useful, but the Action Plan could identify which actions the Facility has determined need to be taken before the next compliance visit. • The Facility data identified areas of need/improvement. For example, the Self-Assessment reported Provision V3 was not in compliance because of the percentage of deficiencies requiring action that were not completed. • The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. For example, the Action Plan stated, "Email Deficiency Requiring Action to individuals responsible for the deficiency noting expected completion date." This is the current process. It also stated the audit findings would be presented "monthly at SA-PIC for analysis using CATW2." Again, this is the current process. No actions were planned to make the current process effective in addressing the need to improve completion of actions when there was an identified deficiency. The Facility should examine its Action Plan and make appropriate modifications. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: The process for filing and purging in the record differs at RGSC from other facilities in that staff of the Health Information Management (HIM) Department do all filing and purging. Improvements continued to be made in the records, both in terms of presence of documents and meeting Appendix D requirements. A vacancy in the Unified Records Coordinator position caused a lapse in auditing to determine whether records were used in decision-making; that position has been filled. **Provision V1:** The Facility continues to maintain a Unified Record that includes all required components and in which documents can usually be found. Over 90% of documents were present and current. Records comply with most requirements of Appendix D. Active Records and Individual Notebooks were both secure and accessible to staff. **Provision V2:** Both DADS and RGSC had continued to develop new policies and processes and to revise these as needed. Some policies and procedures still needed development and revision. **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. The process for tracking deficiencies identified during audits had improved; deficiencies that remained open were noted and highlighted, making it easy to track what needed continuing follow up. Correction of deficiencies had improved significantly since the last report. Although the Facility is found in substantial compliance with requirements of this provision, the Facility should identify issues needing systemic improvement and implement effective actions. **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. Problems were found in timely documentation of data, including Aspiration Trigger Sheets and skill acquisition plan (SAP) data. Auditing of meetings and surveying IDT members to assess use of information from the Unified Record had not been done due to vacancy in the URC position.

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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. • 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 guided the transcription of clinical assessments and notice to physicians of reports and notes pending. • RGSC SOP HIM 400-18-ICF provided 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 to require that audits be completed "the 31st day following the annual ISP for each individual" rather than the 30th day; this was done because the IDT was allowed 30 days to complete assessment and ISP information, and the audits needed to follow filing of that information, if available. The timeline	Substantial Compliance

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		for informing disciplines of Deficiencies Requiring Action (DRAs) was revised from one week following the audit to one day following the audit for any and all assessments falling out." There was no timeline provided for DRAs other than assessments. In additions, DRAs were to be documented in the RGSC Monthly Audit Findings database for tracking through to completion. Changes were also made in what audit information is to be reported monthly. 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 Monitoring Team asked home staff for the Individual Record at the home for Individuals #45 and #94. Staff were immediately able to locate and provide those records. <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, 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 URC position was vacant for a time; the current URC began 1/2/14. 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. At the last compliance visit, the Facility provided the	

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		training materials and competency test. The materials did not indicate there was any practice on documentation. The competency test consisted of several questions about the topics covered in the training. At this visit, the Facility did not indicate that there had been changes in training. The Monitoring Team continues to suggest 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. <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. The Monitoring Team checked the accessibility and security of active records for Individuals #29, #33, #35, #45, #94, and #103. For four individuals, at least one chart of the record was not present. For three of four individuals for whom at least one chart was not present (75%), the charts were checked out. <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: • Record Audit Tools for last 10 audits conducted: February 2014 (Individuals #62, #97, #103, and #114) and March 2014 (Individuals #11, #29, #51, #66, #79, and #82) • Active Record, Individual Notebook, and Master Record for Individual #103 (selected by computer randomization from among admissions since the last compliance visit) • ICF Monthly Delinquency Reports to the Settlement Agreement-Program Improvement Committee (SA-PIC) for January, February, and March 2014 Data were reported monthly to SA-PIC monthly through a document called the "Monthly Delinquency Report." The Monthly Delinquency Reports provide graphs of "% ICF assessment/Record Completion Compliance" from March 2013 through March 2014. These graphs provided data on assessments completed and on record completion. Monthly percent of assessments completed from October 2013 through March 2014 ranged from 89% to 92% (it should be noted that the audits are done 31 days following the annual ISP meeting, so this audits presence of assessments at that time and not of	

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		their completion when required prior to annual ISP planning meetings); in fact, timely completion of assessments averaged 43% according to the Facility's Assessment Report. Percent of record completion was consistently 0%; the Facility used a high standard for this, in that a record had to meet Appendix D standards for current, complete, and accurate. Any missing or inaccurate document in an entire Active Record and Individual Notebook could lead to a finding that it was not complete. The Facility might consider using a more sensitive measure, such as percent of required documents present and current in the record. Although the Monthly Delinquency Reports reported the inter-rater agreement on presence of document for five records audited, they 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. The number of deficiencies reported in those monthly reports is not broken out by problems with whether documents are or are not present or current, or whether they do not meet Appendix D guidelines. Therefore, the report does not provide information on presence of documents. As reported below in Provision V3, the Facility had implemented a Monthly Audit Findings table that listed each cited deficiency for each record. One column was "Category of Corrections"; this column had categories such as "Missing document" and "Missing current" which accounted for nearly all the deficiencies (it was unclear whether problems with Appendix D requirements were listed on this table). The Facility could easily use the information from that table to calculate percent of documents present and percent current. The Monthly Delinquency Reports also included a list of deficiencies cited each month by responsible department. For the three months of January, February, and March 2014, the number of deficiencies cited was, respectively, 64, 45, and 51. This did not identify the types of deficiencies (which would be helpful in identifying actions to improve), and there was no graph or table that would make it easy to see if the number of deficiencies was changing. The Delinquency Reports also included a graph of percent of Active Records, Me Books, and Master Records established; these were consistently 100%. This graph also included % of Record Compliance with Appendix D Guidelines. These ranged from 56% to 81%. Three other data sets—"Summary of Deficiencies Cited," a table of "Inter-Rater Findings," and "% of Overall Inter-Rater Agreement" are discussed below in Provision V3. The Monitoring Team selected a record to audit by computer randomization from among the individuals who had been admitted since the last compliance visit. This record was for Individual #103. The Monitoring Team audited the Active Record, which had two charts, and the Individual Notebook, using the same tools used by the Facility. The Monitoring Team also reviewed the Master Record.	

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		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 without including the items 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 percentages found at the last compliance visit.	

Record	Chart 1	Chart 2	Me Book	Total
Presence of Documents	86%	94%	78%	91%

It should be noted that, consistent with findings in Section S and as noted elsewhere in this report, skill acquisition plans (SAPs) were not present in the Individual Notebook.

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 #103. All required documents appeared to be present, and the documents were filed neatly and were easily accessible.

Consistency with Appendix D Requirements: As reported above, 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.

For Individual #103, the following table provides the percent of rating Appendix D requirements as met. Many requirements were not applicable for a given tab. For

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		example, documents could not have entries in reverse chronological order if there was only one document of that type in a tab. Also, legibility in handwritten documentation were not applicable when all documents in a tab were typed. Data from Monitoring Team audit are presented for applicable documents.	

Record	Chart 1	Chart 2	Me Book	Total
Appendix D Compliance	88%	89%	100%	89%

As noted above, the Monthly Delinquency Report did not report the percent of Appendix D guidelines met but instead provided a Record Compliance score that required all Appendix D requirements to be met, thus resulting consistently in 0% compliant. The Facility provided a table of Appendix D compliance by record. This table listed 12 Appendix D requirements. For each record audited, the table reported whether each requirement was met. The table reported the percent of records audited from September 2013 through the first audit of April 2014 for which each requirement was met; it also provided compliance broken out by month and quarter for all requirements. Overall percent compliant ranged from 0% for "documents and documentation were accurate, current and complete" to 100% for "signature legends for documentation with MARS," "Electronic records are protected through security access or passcodes(,)" and "There was no evidence of falsification(.)" Nine requirements equaled or exceeded 88%. Signatures meeting all requirements complied for 29% of records, and not having gaps or blank spaces complied for 31%. Consistent with the graph in the Monthly Delinquency Report, total compliance per month ranged from 56% to 81%.

There were also graphs in the monthly reports titled "% Assessment Compliance by Discipline Below 90%"; the Facility stated that these reported on numerous documents, not only assessments. Except for documents for which Pharmacy was responsible, nearly all disciplines showed at least 70% compliance each month (with most above 80%).

Clinical Work Station (CWS)

Documentation in the CWS was, of course, legible and readable. Records were accessible to designated staff but the process continued to be cumbersome. Integrated Progress Notes (IPNs) were available by discipline, but there was no easy way to compare IPNs from different disciplines for a specific issue. This continued to make it difficult to tie clinical data together in a meaningful way to gain a clear and comprehensive picture of an individual's clinical status, as a single issue or concern could not be tracked chronologically without opening one discipline, then closing that and opening another to find relevant notes—a time-consuming process. Some documents, such as some

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		physician documentation, were printed so that a hard copy could be kept in the Active Record for easy access. The MOSES and DISCUS screening information had been added to the CWS. The Facility reported the screening information was being entered from the hard copies by clerical staff; the Monitoring Team did not ask, and the Facility did not report, whether the physician needed to finalize the information after entry. Conclusion The Unified Record contained all required components. Active records were in good condition. There was some evidence that most required documents were present for most individual records. Most Appendix D requirements, but not all, were consistently complied with. Although records were not complete and therefore did not meet the Appendix D standard as defined by RGSC, most documents were present. The records are substantially compliant.	
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.	Facility Process to Develop and Revise Policies 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. The Facility reported the process for training staff on new and revised policies had not changed since the last compliance visit. Development and Revision of Policies to Implement Part II of the Settlement Agreement 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. In response to a request for all new and revised State and Facility policies implemented since the last compliance visit, RGSC provided several Facility policies but no DADS policies. The Facility also provided a table titled "RGSC Policy Review." This table listed revised policies, with dates the steps in the approval process were completed, who the policy was distributed to, and notes for some policies. This table included departmental policies as well as policies in the ICF-IID policy manual. Including all policies in this way permitted the Facility to have a single location to track all policy revisions, which should be helpful in monitoring whether departmental policies are kept up to date and are revised as needed to ensure consistency with ICF-IID policies; this is an excellent practice. In reviewing policies provided for other Sections of this report, the following policies had been revised since the last compliance visit in addition to those listed by the Facility: • DADS Policy 001.2 Use of Restraint (4/4/14)	Noncompliance

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		• DADS Policy 008.3 Behavioral Health Services Department Policy (11/5/13) • RGSC Environment of Care Manual: Standard Operating Procedure (SOP) EC 300-07A, Safety/Risk Management/Infection Control Committee Policies and By Laws, Review/Revised: December 2013 • RGSC SOP QM 100.011 Quality Assurance Plan/Program Narrative – ICF (4/14) • RGSC SOP QM 100.15 DADS Quality Assurance Expectations (4/14) An example of improvement in policy relates to the Quality Assurance (QA) program; the Facility had updated its policies since the last review. Most significantly the Facility had incorporated multiple Facility-wide QA related policies into one over-arching policy entitled Quality Assurance Plan/Program Narrative – ICF. 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. In its last report the Monitoring Team noted that 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. This was much improved. The new comprehensive QA policy clearly articulates a description of the SA-PIC and expectations for its work. There were examples throughout the report of Facility policies that were comprehensive and provided guidance to implement the requirements of the Settlement Agreement. Some examples included: • RGSC did have a comprehensive communication procedure/policy that addressed all components of a functioning system. • The Facility had a comprehensive physical and nutritional management policy. <u>Training on Policies</u> The QA Director reported that policies are available on Sharepoint for all staff. In addition, the Facility had recently completed Manual Mania training, a refresher about the policy manual, for all staff. The Facility provided the training handbook given to staff. This handbook included the Facility mission; described the various policy manuals; reviewed several policies including Abuse/Neglect/Exploitation, Reporting of Ethical Issues, and emergency codes including fire reporting and evaluation, medical emergency, bomb threat, and workplace violence; and some general patient safety requirements for staff to follow. The 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	

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		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>Areas in which Efforts are Needed</u> There remained areas in which either policy needed to be developed or implementation needed to be monitored and improved. For example: • As reported in Provision C1, the Facility had two separate and distinct policies/protocols 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. As noted in Facility review of restraint episodes (Provisions C.5 and C.8) certain actions by nurses and physicians (use of medication as restraint) were incorrectly not viewed as restraint at the time of medication administration or were correctly viewed as not being restraint but staff chose to use restraint forms to document the medication administration. In any event, administration of these medications were included in the list of chemical restraints for crisis intervention presented in the document request to the Monitoring Team. The Facility reported that the nursing policy was not in effect for the ICF-IID portion of the Facility, but it was unclear that staff were aware of that, and implementation was not consistent with the ICF-IID policy. • As reported in Provision M1 regarding hospital liaison nurse activities, documentation did not meet the requirements in DADS Policy 010.3 Nursing Services, 6/17/13, DADS Nursing Protocol: Hospitalization, Transfers and Discharges. • The nursing administrative staff reported they were not aware of several DADS nursing related policies, procedures, guidelines, and protocols were revised and sent out in December 2013 and January 2014; Facility policies and practices had not been operationalized and localized to ensure consistency with these revisions. • The Facility did not have a comprehensive OT/PT policy. • DADS policies on guardianship and rights assessment did not provide guidance on assessment of capacity of individuals to make decisions. <u>Conclusion</u> Processes for development, revision, and implementation of policies were in place. There remains a need for policies to address a few requirements of the Settlement Agreement. The Facility needs to ensure policies are implemented accurately.	

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V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	Audit Policy and Process 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 complete deficiencies requiring action, and reporting of results. This policy had been revised to require that audits be completed the 31st day following the annual ISP for each individual to allow for the timeframe for all documents/assessments to be completed. The policy described records for audit as being for all individuals who had an ISP annual meeting during 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 Facility provided a table called "Compliance by Record Report" that provided results from a minimum of five and maximum of eight records that had been audited per month from September 2013 through March 2014. The Facility also provided 10 audits conducted in February and March 2014 (although only four were completed in February, the audit for records of the fifth individual, Individual #79, was due and completed 3/3/14). 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. Some information on the CWS was considered part of the Active Record and was included in the audit. Attachments to the policy included the Active Record/Individual Notebook Audit Tool, the form for providing notice of Deficiencies Requiring Action, an example of the monthly audits findings table and of the Section V Appendix D Compliance Report, and example of the Monthly Delinquency Report, and both the Audit Tool Cheat Sheet updated 4/3/14 and Inter-rater Questions/Discussions Log through 11/2013. The Audit Tool Cheat Sheet is based on the table of contents of the Active Record. For each tab of the record, it lists the documents and, for each document, definitions or instructions for rating whether the document is present. The Inter-rater Questions/Discussions Log is a record of items that reflect lack of agreement between raters and need to be discussed and documented; it provides a record of revisions to instructions for auditing specific items as well as of actions (and who is responsible for actions) determined through the audits to be needed; the Facility provided a version of this document updated 5/1/14. Having these documents provides a record of decisions	Substantial Compliance

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		on definitions and procedures. This also is useful for training new auditors; according to the Facility, the information from these was reviewed with the new URC before she began auditing. The Monitoring Team reviewed these for guidance when auditing the record reported in Provision V1. The Monitoring Team requested audits conducted between providing the document request and the beginning of the compliance visit; this would have been audits conducted in April 2014. The Facility did not provide the audits conducted in April. <u>Interobserver Agreement/Interrater Reliability</u> The Facility had a process for evaluating interobserver agreement on audit findings for each audited component of the Unified Record. From the five audits, the Facility selected one record for audit. Because the HIM staff did the filing and purging, the Facility assigned a records management staff from the Facility's outpatient clinic (a separate part of the Facility with separate records) to do an independent audit. Data on reliability were reported monthly to SA-PIC monthly the "Monthly Delinquency Report." A table of Inter-Rater Findings provided data from the one or two records each month reviewed by two raters. The table reported data by Active Record charts 1, 2, and 3, Individual Notebooks separately for Residential and Vocational, and Total for Documents Present and for Appendix D Requirements. All agreement percentages except one exceeded 80% (the March 2014 Vocational Individual Notebook had agreement of 79%) with nearly half exceeding 90%. This was an acceptable level of agreement. A graph of Overall Inter-Rater Agreement showed percentages for the total ranging from 81% to 93%. At the last compliance visit, the Monitoring Team and HIM independently audited a record on the same day. Agreement on rating whether documents were present was acceptable for the Active Record and slightly below for the Individual Notebooks and was within the range reported by the Facility for reliability. For Appendix D requirements, agreement was slightly lower, but mostly as a result of differences in rating whether documents were in reverse chronological order when there was only one document of a particular type in the record. As recommended by the Monitoring Team, the Facility defined this item more clearly. Because of the levels of agreement reported by the Facility and the generally acceptable level of agreement between the Facility and the Monitoring Team at the last visit, Monitoring Team did not conduct a reliability audit with the Facility at this visit. <u>Audit Findings</u> As reported in Provision V1, the Monitoring Team determined, from the reports provided by the Facility, the monthly percent of Appendix D requirements found compliant was in	

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		the range of 56% to 81%, although the Monitoring Team audit of one record found 89% compliance. <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 (DRAs) 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 DRA process had remained the same since the last compliance visit, but the process for tracking deficiencies had improved. The Facility developed a table of audit findings each month. The table included the date of audit, individual, discipline, specific correction needed, category of corrections, what evidence would be required, and the dates the responsible staff was notified and the correction was completed. One column listed the status of the correction; deficiencies that remained open were noted and highlighted, making it easy to track what needed continuing follow up. The Facility provided this Monthly Audit Findings table for DRAs identified in audits conducted in February, March, and April 2014. Nearly all listed DRAs were reported as "Missing," "Missing document," or "Missing current." There were no other DRAs for not complying with Appendix D requirements. For the DRAs from audits conducted in February 2014, 48 of 63 (76%) had been completed; for audits conducted in March 2014, 27 of 45 (60%) had been completed. This was a significant improvement compared to the findings at the last compliance visit, when the Facility reported approximately 25% of DRAs for a six month period had been closed. For April 2014 audits, a few due dates had not yet been reached by the beginning of the compliance visit; given that policy requires completion of action in response to a DRA to	

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		be completed within one week, it was unclear why some due dates extended nearly a month. Overall, completion within one week as required by policy was inconsistent. Nonetheless, this process facilitated continuing follow up until closure. The Facility provided several examples of HIM Deficiencies Requiring Action forms. These included the action needed, who the action was assigned to, when notification was provided, when the correction was due, and (if completed) when it was cleared. There were also boxes for Expected Outcome, Type of Evidence Submitted, and Date Evidence Submitted, but these were not completed on any of the documents provided. This form and process, if fully utilized, should provide an effective means to follow up. There was no indication of how the process addressed DRAs that involved Appendix D requirements such as signatures and no gaps. These were not listed on the DRA table, and no DRA forms provided examples. These processes should be applicable to those deficiencies as well as to missing documents. Overall, the process seemed to be an effective way to provide notice of the need for corrective actions and to track whether those actions were completed. <u>Review of Trends and Use of Audit Information for Systemic Improvement</u> At the time of the last compliance visit, the Facility had identified lack of timely assessments as a systemic issue requiring attention. As a result, Nurse Case Managers were required to work overtime to complete pending items, and a staff was provided half time to assist Case Managers. No other systemic actions were reported during this period. <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. Although there remained a need to improve completion of DRAs timely, the percentage closed had increased significantly, possibly due in part to an improved process for tracking completion. The Facility should identify issues needing systemic improvement and implement effective actions. Nonetheless, the presence of this system, along with indication from the relatively high levels of presence of documents and of compliance with most Appendix D requirements that the audits may be effective, merits a finding of Substantial Compliance.	
V4	Commencing within six months of the Effective Date hereof and with	The Monitors and the parties agreed to a list of six actions that the facilities would engage in to demonstrate substantial compliance with this provision item. These actions	Noncompliance

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	full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	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. Checking out of Active Record charts was generally done correctly. The Share Drive made assessments readily available to clinical staff, residential directors, QIDPs, and others who might need to refer to them. Acute Care Plans contained instruction sheets for direct support professionals (DSPs). <u>Documents are Filed in the Record Timely and Accurately</u> The Monthly Delinquency Reports reported that 0% of records audited were compliant for records completion. 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 • ISP Assessment Report (tracking log) November 2013 through March 2014 • Reviewed the ISP Assessment Report (tracking log) November 2013 through March 2014 and 2014 Assessment Report for reports due May 2014 as of the compliance visit • Reviewed the assessments prepared for the admission ISP meeting for Individual #7 • Reviewed a sample of two Individual Support Plans (ISPs)—one selected by the Facility from El Paisano and one from La Paloma 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. The Facility provided monthly Assessment Reports tracking assessment completion for November 2013 through March 2014. 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 those months, timely completion rates ranged from 36% to 58%. These figures were consistent with reports from the last compliance review period. Record audits conducted a month following the annual ISP meeting found approximately 90% of assessments completed. Although it is good to have them completed, information from assessments cannot be used in making decisions at the ISP meeting about services, supports, treatments and interventions.	

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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, neither (0%) had all assessments included and completed on a timely basis prior to the ISP annual meeting. Overall for this sample of 32 assessments that were required to be completed 10 working days prior to the ISP date, 18 (56%) were completed on a timely basis. As reported in Provision R2, for eight of 13 individuals sampled (62%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP. There were some positive signs of progress. As reported in Provision P1, seven of eight individuals' OT/PT assessments sampled (88%) were dated as having been completed at least 10 working days prior to the annual ISP. Assessments for individuals who are admitted were completed timely, a positive finding. Four of four newly admitted individuals (100%) received OT/PT and communication assessments at least five working days before their admission ISP meetings. For Individual #7, most required assessments were completed more than five working days prior to the admission ISP meeting. <u>Data Are Documented/Recorded Timely On Data And Tracking Sheets</u> Problems were found in timely documentation of data, including: • Issues with the Aspiration Trigger Sheet; these included: o The trigger sheet contained multiple gaps in data due to lack of completion. o Triggers when occurred were not consistently documented on the trigger sheet. • Skill acquisition plan (SAP) data for current training programs were not consistently recorded timely. DSP staff in various locations was asked to provide the program data books for at least three individuals. Alternating between individuals, the data sheet for the first or second skill acquisition program in the data book was selected for review. This resulted in 16 training programs for 14 individuals being included in the sample. These individuals included Individuals #5, #12, #21, #31, #33, #55, #61, #77, #97, #98, #103, #115, #139, and #140. Individuals #97 and #139 were included in the sample twice as staff in two separate locations selected their program books.	

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		• Two of 16 training data sheets (12%) were missing from the training data books. • Data sheets were lacking current data for 12 of 16 training programs (75%). • As reported in Provision P2 regarding the PNMP and OT/PT-related SAPs, missing or inaccurate data was a pervasive issue and noted with all individuals in Sample P.1. Examples consisted of either data not being recorded or data being recorded when the individual was not present. • As reported in Provision R3 regarding indirect communication supports, there was a lack of consistent data gathered to allow for adequate review and revision of the goals. This was pervasive issue that plagued all SAPs and not just those related to Speech. For example, Individuals #97 and #98 both had extensive data points missing throughout the month and quarter. <u>IPNs Indicate The Use Of The Record In Making These Decisions (Not Only That There Are Entries Made)</u> Although not specifically involving IPNs, there were some indications that information in the record was not always used in making decisions. For example, as reported in Provision P2, monthly progress notes did not contain information regarding whether the individual showed progress with the stated goal nor were recommendations/revisions to the OT/PT intervention plan recommended as indicated related to the individual's progress or lack of progress. <u>Staff Surveyed/Interviewed Indicate How The Unified Record Is Used</u> The Facility's process to survey staff regarding use of the Unified Record had been discontinued temporarily in June 2013. This was resumed beginning in January 2014, but data were only available for that month and not for any more recent months. <u>Observation At Meetings, Including ISP Meetings, Indicates The Unified Record Is Used and Data Are Reported</u> To assess use of information from the Unified Record during IDT meetings, the Monitoring Team observed the ISP annual planning meetings for Individuals #126 and #140, the admission ISP meeting for Individual #7, and the quarterly psychotropic medication review for Individual #51. The Active Record was present at all meetings. Use of information from records was variable. • At the meeting for Individual #51, both the psychiatrist and the psychology assistant referenced data from the quarterly information on the positive behavior support program (PBSP). The QIDP presented data on the number and dates of incidences of vomiting and on the dates of cluster seizures. Discussion of refusals to go to appointments, however, involved reports of impressions rather than data. The dietitian reported the individual refuses to be weighed, and she looked in the record for December weight. Specific medication	

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		dosages and some relevant lab values were provided. • At the ISP Preparation meeting for Individual #85, the IDT referred to the record several times. However, information from the record was mostly discussed in generalities instead of specific information including data. For example, the QIDP looked in the record to review progress on action plans, a positive finding. In presenting that information to the IDT, she simply reported for action plans, "making progress" without providing any data that would help the IDT to assess the pace or significance of progress. The QIDP did state, "We haven't seen her have UTIs" and "Going to Retirement every day," which likely summarized actual data. The Nurse looked in the record for date of dental appointment and for when the individual had prn pain medication, and provided the actual information. Information on frequency of pain medication led to an action step to refer immediately to the primary care provider for assessment, rather than to wait for the ISP annual meeting, indicating the objective information influenced a decision on care. • The record was present at the ISP annual meeting for Individual #140. However, information from the record was not used effectively. For example, when discussing a program to use an electric toothbrush, no data were presented, just impressions; the program was continued. When discussing a skill acquisition program (SAP) to apply lotion, staff reported she can already do that. No data were reviewed, and the program was continued in spite of the possibility that it was intended to teach a skill she already had. In reviewing the money management SAP, the IDT did not look in the record to determine the individual's current skill (for example, by reviewing the Functional Skills Assessment (FSA); instead, the QIDP stated she would have to check the FSA (which indicated she would use information from the record, but which did not allow for that information to be provided to the IDT members for team decision). The QIDP did provide data on number of falls; a graph by month was included in the ISP Guide so it was available to all IDT members. • At the ISP meeting for Individual #126, the Active Record was present, and CWS was onscreen for quick reference. The Integrated Risk Rating Form (IRRF) draft included information on history, including data on labs, findings from assessments, and current supports. During the discussions, there was little reference to data. The QIDP did state that she would discuss with Behavioral Health Services how to get data on self-injurious behavior (SIB), as the psychology assistant stated baseline data show infrequent SIB but staff report it occurs daily; it was positive to find that the inconsistency was recognized and that action will be taken to get more accurate data. A significant concern was that there was a great deal of health information in the record that was not reported to the IDT. For example, there was discussion of whether or not the	

#	Provision	Assessment of Status	Compliance
		individual had a history of fractures. A nurse stated there was no history, but the QIDP recalled one specific fracture. Nobody checked the record. The Monitoring Team found an assessment in the record that reported a history of multiple fractures, some of which had also been listed in the IRRF. This information would be important for decisions about healthcare. Refer to Provision L1 for additional information. • The Active Record was present at the admission ISP meeting for Individual #7. Because this was the 30-day meeting, there would not be a great deal of data to be considered, and there was no discussion of data. Assessments were available, The Facility was not carrying out observational or other assessments of meetings to monitor use of information from the records. <u>Conclusion</u> There was progress in timely completion of assessments. Use of information from the record for decision-making during meetings was variable, although the Active Record was consistently available; the Facility did not have a monitoring process in place to assess this. Problems were found with timely documentation of data. There was a lapse in the use of staff interviews regarding use of the record.	

List of Acronyms

Rio Grande State Center

May 19-23, 2014 Compliance Visit

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACP	Acute Care Plan
ADAMS	Anxiety Depression and Mood Scale
ADHD	Attention Deficit Hyperactivity Disorder
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
BHS	Behavioral Health Specialist
BIR	Behavioral Incident Report
BMC	Behavior Management Committee
BMD	Bone Mineral Density
BP	Blood Pressure
BSC	Behavior Support Committee
BSP	Behavior Support Plan
BSPPS	Behavioral Support Program for Psychiatric Symptoms

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
CoS	Change of Status
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
HPI	History of Present Illness
HRC	Human Rights Committee
HRO	Human Rights Officer
HST	Health Support Team
HT	Habilitation Therapy
IBHA	Integrated Behavioral Health Assessment
IBW	Ideal Body Weight
IC	Infection Control/Informed Consent
ICF	Infection Control Form
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
IMM	Incident Management Meeting
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
NSI	Non-serious Injury Investigation
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
SPA	Speech Pathology Assistant
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