United States v. State of Texas

Monitoring Team Report

Rio Grande State Center
March 1-5, 2010

Date of Report: April 20, 2010

Submitted By: Michael J. Davis, Ph.D.
Monitoring Team:
Dwan Allen, RNC, BSN, NP
James Bailey, MCD-CCC-SLP
Douglas McDonald, Ph.D.
Scott Umbreit, M.S.

Table of Contents

Introduction

I. **Background** - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement covers 12 State Supported Living Centers, including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facilities for the Mentally Retarded (ICF/MR) component of Rio Grande State Center. In addition to the Settlement Agreement (SA), the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three (3) Monitors responsible for monitoring the facilities' compliance with the Settlement Agreement and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor is responsible for conducting reviews of each of the facilities assigned to him/her every six (6) months, and detailing his/her findings as well as recommendations in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 are considered baseline reviews. The baseline evaluations are intended to inform the parties and the Monitors of the status of compliance with the SA. This report provides a baseline status of the ICF/MR component of the Rio Grande State Center.

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.

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 SA.

II. **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 March 1-5, 2010, the Monitoring Team visited Rio Grande State 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. This allowed the Monitoring Team to gain some basic knowledge about facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans (PSPs), Behavior Support Plans (BSPs), documentation of plan implementation, progress notes, community living and discharge plans, and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. 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 being implemented.

(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, PSP team 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.

(e) **Other Input** - The State and the U.S. Department of Justice also scheduled calls to which interested groups could provide input to the Monitors regarding the 13 facilities. The first of these calls occurred on Tuesday, January 5, 2010, and was focused on Corpus Christi State Supported Living Center. The second call occurred on Tuesday, January 12, 2010, and provided an opportunity for interested groups to provide input on the remaining 12 facilities.

III. **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 and each chapter of the Health Care Guidelines.

The report begins with an Executive Summary. This section of the report is designed to provide an overview of the facility's progress in complying with the Settlement Agreement. As additional reviews are conducted of each facility, this section will highlight, as appropriate, areas in which the facility has made significant progress, as well as areas requiring particular attention and/or resources.

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports and includes some additional components which 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 SA and each of the chapters of the HCG, 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) **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;
(c) **Assessment of Status:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or non-compliance, 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;
(d) **Facility Self-Assessment:** A description is included of the self-assessment steps the facility undertook to assess compliance and the results thereof. The facilities will begin providing the Monitoring Teams with such assessments 14 days prior to each onsite review that occurs after the baseline reviews are completed. The Monitor's reports will begin to comment on the facility self-assessments for reviews beginning in July 2010;
(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. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. However, 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 SA.

IV. Executive Summary

At the outset, the Monitoring Team would like to thank the management team, staff and individuals served at Rio Grande State Center (RGSC) for their welcoming and open approach to the first monitoring visit. It was clear that the State's leadership staff and attorneys as well as the management team at Rio Grande State Center (RGSC) had encouraged staff to be honest with the Monitoring Team. As is reflected throughout this report, staff throughout the Facility provided the Monitoring Team with information requested, and were forthright in their assessment of the Facility's status in complying with the Settlement Agreement. This was much appreciated, and set the groundwork for an ongoing collaborative relationship between RGSC and the Monitor's Office.

The baseline tour provided an opportunity to become familiar with the policies, procedures, processes, and structure of RGSC. Team members used this time to meet and discuss with a wide range of facility staff to provide an understanding of structure and services, and to develop a collaborative approach to the review and improvement process. The team examined a great deal of documentation and carried out many observations and interviews

in order to evaluate the status of the facility practices. The report describes status of provisions but does not provide decisions about compliance with provisions; that will begin at the first compliance review.

RGSC is unusual within the Texas system of state-operated facilities serving people with intellectual disabilities in that the Center has three components: the Intermediate Care Facility for the Mentally Retarded (which was the subject of this tour and report), a program serving people with mental illness, and a regional health center. This provides advantages and disadvantages. One advantage is the beginning of development of an electronic health information system as an outgrowth of establishing such a system for the program serving people with mental illness. A disadvantage is the complexity of development of policies and procedures. The monitoring team encourages RGSC to identify ways in which the resources of all components can assist each other in improving quality and providing services.

One issue that may be critical to the ability of Rio Grande State Center (RGSC) to meet the provisions of the SA relates to many areas of improvement and does not fit within any one section of this report. Therefore, it is being included only in the Executive Summary. The ICF/MR program at RGSC served 71 people in residence during the visit but has only two residential sites. One residence served 30 people; the second served 41 people. Although only two or three people shared a bedroom and a number of small rooms were available for a few people to congregate at a time, the central area was the hub through which people passed in going in and out, and often many people were in that area. Furthermore, staff may have been assigned to one area of the residence but often had to assist or provide intervention with many different individuals. During high-traffic times such as when people left for or returned from daytime activities, the central area was bustling, and it was difficult for staff to provide individual attention. During mealtimes, many people would be in one of the dining rooms, making it difficult to provide the supervision and assistance needed for safety. Psychiatric Nurse Assistants (PNA), the staff who provided direct supports, were responsible for too many people to permit them to receive thorough competency-based training and know the PSPs and services for each individual for whom they had responsibility to provide care. The monitoring team strongly recommends that RGSC explore ways to establish smaller residences.

Although RGSC has much work to do to meet the provisions of the Settlement Agreement (SA), there are also positive practices in place that should lead to improved outcomes. For example, individuals and Legally Authorized Representatives (LARs) are provided many opportunities to learn about community living; at the same time, the preferences and wishes of individuals are supported. Also, RGSC has had great success in reducing the use of restraint for behavioral episodes.

Staff are making a serious effort to improve services and comply with the SA. They demonstrated a great interest in getting new ideas and learning from the monitoring team.

A great deal of data is available for quality enhancement and trending. These data can serve as the basis for an effective quality review and improvement system.

Following is a summary of specific findings.

Use of Restraint

Use of restraint for non-medical purposes has declined and is relatively infrequent. All use of non-medical restraint is treated as an emergency use; restraint cannot be authorized on a non-emergency basis. The use of pre-treatment sedation is more common; tracking of pre-treatment sedation and development of programs and services to reduce its need should be addressed.

Abuse, Neglect, and Incident Management

Staff are all aware that RGSC does not tolerate abuse. Staff can describe what constitutes abuse, neglect, and exploitation. Policies and practices are fundamentally sound. RGSC needs to ensure it reviews data on allegations, investigations, and injuries in the ICF/MR component to determine trends.

Quality Assurance
RGSC has many elements of a Quality Assurance plan in place or under development. Much of what is in place grew from systems in place to comply with the MI section of the organization. Care will need to be taken to ensure plan elements for the MR section are specific to MR requirements. At this point RGSC's major task is the development of a comprehensive and detailed quality assurance plan that meets all the requirement of state policy. Equally important, is to assess the systems they now have in place, including the data collected, aggregated, and trended and determine how best to use it for future planning and decision-making.

Integrated Services
Planning of services and supports is not interdisciplinary. Disciplines do their own assessments. The Personal Support Team reviews recommendations, but there is little substantive interdisciplinary discussion and coordinated decision-making. Clinical assessments often do not provide adequate detail to assist other disciplines in planning.

Assessment of Risk
Throughout the report are indications that assessment of risk is not consistent with clinical need and does not adequately trigger a risk-based frequency of assessments. As a result, intervention may not be timely if an individual's health or behavioral risk changes. In part this relates to the definition of risk in DADS policy. In part it relates to clinical assessments that do not contain comprehensive and detailed information and may include vague language. In part it is due to a lack of use of specific guidelines for rating risk.

Psychological Services
RGSC is currently faced with a variety of limitations in meeting the behavioral and mental health needs of the individuals living there. At the core of many of these issues is the minimal number of psychology personnel employed by the facility. At the time of the site visit, RGSC did not employ a director of psychology, although the facility was recruiting to fill the vacant position. Many of the psychology personnel lack basic knowledge of applied behavior analysis or the evidence-based approaches to behavioral intervention. As a result, assessments of behavior are inadequate and fail to capture the relevant components of the behaviors in questions. This in turn results in behavioral interventions that lack validity and cannot be supported as being beneficial.

Competence in applying behavioral principles is also lacking in staff members outside of the Psychology Department. As a result, numerous undesired behaviors continue without intervention or are inadvertently strengthened by inappropriate interventions

Substantial limitations are also apparent in efforts by RGSC to document and monitor behavioral interventions. Data collection procedures lack individualization and sophistication. In addition, data may not be collected or interpreted for several weeks. When data are available, interdisciplinary teams often fail to modify treatment plans according to data trends.

Nursing
Because of vacancies, nurses from agencies provide some coverage. Recruiting for additional nurses is ongoing. Nursing policies are not yet aligned with the Settlement Agreement or Health Care Guidelines. Documentation and records are disorganized. RGSC is beginning the development and migration to an electronic record system, and some documentation is currently difficult to locate. Nursing assessments are completed as scheduled but do not contain all essential substantive information. As a result of the limited assessment information contained in the records, as identified above, Nursing Care Plans and/or Health Maintenance Plans were not adequate to meet individuals' total health care needs. There is no centralized system to ensure that health related appointments are kept or that missed appointments are rescheduled.

Pharmacy

The Pharmacy provides service from 8:00 a.m. to 5:00 p.m. Monday through Friday and has Pharmacist on-call provisions for services at other times. Although it was reported that the pharmacist conducts reviews of each individual's medication regimen, and when clinically indicated makes recommendations to the prescribing health care provider, documented evidence of such communication was not noted in the limited record review of individuals. Quarterly Drug reviews were conducted according to policy. When indicated, recommendations were sent to the prescribing physician to accept or reject. No system was in place to track whether the recommendations were accepted or rejected or whether recommendations were implemented. RGSC's medication error data were combined with STHCS. Therefore, it was not possible to discriminate between the two facilities' data. The report did not include any clinical analysis of trends or needed interventions for addressing the prevention of medication errors.

Physical and Nutritional Management

RGSC has a great deal of work to do to ensure safe dining and safe practices at other times that involve swallowing, such as medication passing and oral care. While most individuals have a PNMP, the PNMPs are not considered to be appropriate due to oral hygiene, medication administration, behavioral information, and signs and symptoms associated with aspiration or decline not being included as part of the document. Additionally, the assessment process involved in the development of the PNMPs includes little input being provided by therapy regarding positioning for GERD management, oral hygiene techniques, water safety and presentation of medications.

Staff was not observed referring to dining cards or PNMPs. Monitoring of dining plans is done primarily by staff who do not have specialized training or expertise in swallowing disorders and physical and nutritional management practices. Individuals are provided with care according to the PNMPs at best sporadically.

Physical and Occupational Therapy

Currently, RGSC has one full time Occupational Therapist and a part time Physical Therapist who provides an average of 10 hours per week. RGSC has listed a full time position but as of this review, the position has not been filled. Physical and Occupational Therapy have and continue to provide assessments based on the frequency identified per policy; however, reassessments in response to incidents are lacking for the individuals living at RGSC. While the assessments contained information relevant to areas of functional mobility and adaptive positioning equipment, they were lacking in detail contained in HCG VII. Individuals who have plans in place (positioning, alternative positioning, and/or mealtime) are not consistently provided with supports, and there is not an effective monitoring system in place that provides reliable data and tracking.

Dental

The facility does not provide onsite dental services. Dental services are provided through a privately contracted dentist. Obtaining dental services for individuals who reside at RGSC is challenging. Facility policy on pre-treatment sedation fails to meet the requirements of the Settlement Agreement. There was no centralized tracking system in place to ensure that dental appointments were kept, or appointments missed or refused were rescheduled in a timely manner.

Communication

Currently, RGSC does not have enough clinicians to provide adequate speech therapy to meet the needs of individuals who require these services. Augmentative communication is virtually non-existent, and assistive communication systems are not provided to all individuals who would benefit from such supports. RGSC lacks sufficient coordination and collaboration between and among the various disciplines, especially to address aspects of communication associated with behaviors.

Habilitation, Training, and Skill Acquisition

Record review, observations and staff interviews reflect a process of teaching that is substantially lacking in the components necessary to produce, maintain or strengthen individual skills. Skill assessments lack rigor. Formal teaching plans do not conform to the standards of applied behavior analysis and lack the components necessary to effectively strengthen behaviors. Most training opportunities outside the residences were not directed toward developing skills that would enhance the ability to live in a community setting. Many activities did not train skills that would be needed for community living. Vocational opportunities were limited.

Planning for Movement, Transition, and Discharge

RGSC has many processes in place to educate individuals and LARs about community living options and to provide opportunities to explore those options. The MRA plays an active role in providing opportunities for individuals to experience community living. At the same time, the PSTs have only identified two individuals for whom the PST recommended movement since July 1, 2009.

Guardianship and Consents

RGSC has developed a prioritized list of individuals lacking capacity. The Facility has a active approach to recruiting guardians. To date, this approach has not been effective in recruiting new guardians. This indicates the need for a more focused and intensive effort.

Recordkeeping

RGSC has made the initial steps toward development of an electronic record system. Transition from written records to electronic records must be done carefully to ensure information is available as needed and that the system encourages integrated review and planning across disciplines.

Current records are voluminous. Some documents are placed inconsistently in different locations in different individual records. Some current records are located deep within the record whereas old assessments are in the front. Information from the records is not consistently used during the person directed planning process. Even as the Facility develops its plan to migrate to an electronic record system, the current paper record system needs to be revised so the information needed for planning and providing care and services and for measuring progress and health status are readily available.

In Summary

The above comments summarize the details presented in the full report. Although the challenges presented may seem overwhelming, the monitoring team encourages RGSC to meet those challenges. RGSC is making significant efforts, with the support of the state of Texas, to improve services. Making these improvements is a long-term process. The monitoring team is optimistic that this process can go forward effectively.

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:** Because this is a baseline review a comprehensive set of documents was reviewed to ensure proper identification of subject matter specific information. Similarly, a number of staff, particularly administrative staff, were interviewed on SA provisions relevant to Section C, D, E, and I. The following activities occurred to assess compliance: **Documents Reviewed**: 1. DADS Policy #002.1 Protection from Harm – Abuse, Neglect, and Incident Management, dated 11/06/09. 2. DADS Policy #001: Use of Restraint, dated 8/31/09. 3. Health Care Guidelines, dated May 2009. 4. RGSC Standard Operating Procedure (SOP) MR 700-14 – The Use of Restraint. 5. Restraint records for individuals #1, #36, #47, and #122 6. PMAB Training Curriculum – restraint section 7. Client Record for individuals #5, #35, #79, and # 85 8. All documents referenced in baseline document request including but not limited to: a. incident and injury tracking logs b. restraint tracking logs c. general information about the RGSC. 9. Table of Contents of the RGSC Management Plan 10. Performance Improvement Council (PIC) report 11. Most current Trend Analysis Report (November 2009) 12. Corrective Action Plans (CAP) for 6 most recent incidents 13. Daily Dorm Reports for 2/24/10 14. Incident Management Daily Review minutes for 10/5/09, 9/11/09,3/2/10 **People Interviewed**: 1. Sonia Hernandez-Keeble, Superintendent 2. Blas Ortiz, Assistant Superintendent 3. Mary Ramos, Quality Management Director 4. Bertha Lopez, MR Services Program Director 5. Rosie Sanchez, QE Coordinator 6. Alondra Machado, Data Analyst 7. Megan Gianotti, Assistant MR Program Director 8. Dennis Provaznik, Incident Management Coordinator 9. Myrna Wolfe, QMRP Coordinator 10. Karina Serratos, Facility Investigator 11. Vina Guerrero, Training Director

	12. Vicente Arismendi, Staff Trainer 13. Ray Ramos, Risk Manager 14. Eli Perez, DFPS Investigator 15. Six PNAs **Meetings attended/Observations**: 1. Human Rights Committee meeting 3/4/10 2. Personal Support Team meeting 3/4/10 3. Discharge Planning meeting 3/2/10 4. Incident Management Team meeting 3/2/10 5. Living area observations, including observations of individuals receiving 1:1 supervision. Specific observations of Individuals #4, #27, #51, #82, #113, and #116
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor Assessment: RGSC Standard Operating Procedure MR700-14 – Use of Restraint is a comprehensive set of policies and practices that guide facility practice. It appears to contain the essential element required for good practice. As measured by the results, RGSC has obviously taken steps to reduce the frequency of use of restraint. The most recent trend report shows the average number of restraint events (non medical) as 1.2 per month for the most recent 6 months of the report (June 09 – Nov 09). These data are skewed because of one individual who had four episodes in one day, Eliminating that data would show RGSC had used restraint only 4 times over the 6 month period. The previous 5 months showed a considerably higher rate (2.6 per month). All non-medical restraints are considered emergency restraint. No individual at RGSC has a Safety Plan which is the mechanism by which restraint use can be authorized on a non-emergency basis. Interestingly, when queried, management staff could not identify any specific actions that were initiated to reduce the frequency of restraint use. There are multiple issues noted in this section of the report that need to be addressed through additional training and administrative oversight. A review of training records validated that staff have been trained but the issues noted in Sections C1, C4, C5, and C6 demonstrate the need for additional and more effective training. Through interview and demonstration the quality of the restraint training provided by the staff trainer was good. PNAs interviewed reported the use of restraint as a very infrequent occurrence in their daily work. RGSC may be well served by creating some type of reference tool that staff can use when they find themselves in a position to use restraint and need a quick "refresher" on the most significant policy and documentation requirements. The tracking and trending data maintained by RGSC contains appropriate data elements. RGSC intends to expand the data set to include tracking and trending of medical restraint. The data would be more useful if the reports could be generated on a timelier basis

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	RGSC's Standard Operating Procedure MR 700-14 – The Use of Restraint is a 25 page document that represents a comprehensive set of policies and procedures that address facility practices. Section 1.D.1 prohibits use of prone restraints and any physical restraint where the individual is in a supine position. A review of 7 restraint records did not reveal any use of prone restraint. In staff interviews, including Direct Care staff, it was evident that the facility prohibition against use of prone restraint was well understood. SOP MR 700-14 addresses other areas of the SA covering the basic requirements associated with restraint use, prevention of restraint, less restrictive interventions (alternatives to restraint), limitations governing restraint use, application of restraint as a crisis intervention, restraint documentation, restraint monitoring, responsibilities of licensed healthcare professionals, restraint release requirements, restraint review requirements, medical restraint use, staff training requirements, and administrative oversight responsibilities. From record review and staff interviews there are a number of areas for which there is concern with respect to the understanding and implementation of SOP MR 700-14. 1. Section 1.A.2 requires that the Personal Support Team (PST) must ensure that a physician, advanced practice nurse, or physician assistant reviews and updates (at least annually) the factors that must be taken into account for each individual to ensure person specific safeguards should use of restraint become necessary. The PSPs reviewed by the monitoring team did not document that this review was done. 2. Section 1.C describes a large number of less restrictive interventions that staff should consider as an alternative to the use of restraint. From interviews with Direct Care staff knowledge of these alternatives was quite variable with most interviewees having a very minimal understanding of these alternatives, especially when asked to describe their application. It should be noted that the use of restraint at RGSC has significantly decreased over the last year which could indicate that even though staff may have had a difficult time articulating alternatives to the reviewer they in fact are using alternatives that have resulted in far fewer instances of restraint. 3. Section 1.K.2 requires that medical restraint may only be used after less restrictive alternatives have been attempted. Most restraint records reviewed contain a data item labeled "Interventions attempted prior to restraint". Three restraint records for individual #47, who is frequently in medical restraint, did not contain this data item.	

#	Provision	Assessment of Status	Compliance
		4. The definition of prone restraint (p. 24 of MR 700-14) includes the statement "prone restraint does not include brief physical holding of an individual who, during an incident of physical restraint, rolls into a prone or supine position, when staff restore the individual to a standing, sitting, or side-lying position as soon as possible." In instances where this occurs it is important that the specific details of the event be properly documented in the restraint records including the debriefing to ensure staff do not inadvertently develop a practice of holding an individual in a prone position. A restraint record for individual #122 refers to a "horizontal hold" although the narrative description makes no mention of the individual being on the ground. There are two Emergency Restraint Monitoring and Debriefing forms; however, neither includes the name of the staff person who completed them. Policy require debriefing is to be done by the Restraint Monitor after interviewing each of the two staff involved in the restraint; however, the handwriting on the two forms is different leaving the reviewer with the impression each staff person completed a form, not the restraint monitor. 5. Page 21 of MR 700-14, between item 7 and 8 contains the term "ENHANCED SUPERVISION??." It appears as though a definition was meant to be added. On the last page there is an item REVIEWED followed by a date. There is no indication of who the reviewing parties are. While these concerns may seem minor they do raise a question regarding the thoroughness of the development and review of the SOP. 6. Section G.3 requires a restraint monitor to conduct and document a restraint debriefing with the individual and staff involved. The restraint checklist and the restraint debriefing process do not appear to be consistently applied. As a result some elements of documentation mistakes do not get discovered. For example, individual #36 was restrained by personal hold to prevent her from walking in the street. The restraint documentation did not have a release time. In one section of the form it indicates the release was initiated at 9:30am and in another section it indicates observation of the restraint by the restraint monitor began at 9:15am. In the restraint monitor comments it is noted the person was restrained for 3 minutes. In restraint documentation of other individuals the release time was noted in the main body of the record. A proper restraint debriefing process may have identified these issues. In reviewing information presented to the reviewer as "restraint documentation" for six individuals only one (individual #122) included a restraint debriefing or restraint checklist. MR 700 -14 is apparently a relatively recent SOP. From the dates on the document it appears to have been revised in November 2009 and again in February 2010. It is evident to the reviewer that additional detailed training on the requirements contained in this SOP is needed.	

#	Provision	Assessment of Status	Compliance
		In reviewing information that was presented as "restraint documentation" a number of issues emerged. 1. Three records for individual #47 were reviewed. None included a debriefing form. Two did not include the post restraint RN/LVN assessment, and two did not include the observation release codes. 2. A record for individual #1 listed the type of restraint as "other" when the narrative note clearly described a hold. The restraint began at 9:47am and was terminated at 9:50am. The record indicates the restraint monitor was notified at 9:50am, the supervisor at 10:15am, the doctor and nurse at 11:15am (elsewhere in the report there is an entry indicating the doctor was notified at 9:50am and the nurse was notified at 10:30am). A progress note says the physician order for the restraint was written at 9:30am. All this makes a reviewer wonder if any of the information in the documentation is credible. Comments from the restraint monitor indicate the individual calmed down when the restraint monitor provided physical space. This leaves the impression that had staff done that in the first place use of restraint may have been avoided. The debriefing form indicated a lack of awareness by staff of the multiple options that may exist to avoid situations requiring use of restraint with this individual. The staff person's only suggestion was to put the individual on 1:1 even though from the restraint monitor's comments it appeared not having space (which is what a 1:1 would require) contributed to the behaviors leading up to restraint. 3. A record for individual #122 indicates use of a basket hold in the narrative but calls it horizontal restraint when listing "type of restraint. " The main body of the form does not include a release date/time although one is noted later in the documentation in the observation section. 4. A record for individual #36 did not indicate a release date/time. It indicates a start time of 9:30am although in the observation section it indicates observation of the restraint started at 9:15 a.m. (and the restraint ended at 9:18 a.m.). There was not a debriefing form included. RGSC presented a sample form entitled "Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint" and characterized it as the form currently in use although they have a new one they'll be using soon. None of these forms were part of any documentation reviewed. All the above suggests there is a need for additional training in every aspect of restraint policy and procedure and that a QA mechanism needs to be established to identify obvious errors in documentation so that official records are accurate.	

#	Provision	Assessment of Status	Compliance
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	Section 1.I of SOP MR 700 -14 states that the individual must be released from restraint as soon as he or she no longer poses an immediate and serious risk of harm to him/herself or others. The restraint records reviewed one instance of the use of a personal hold for 3 minutes (individual #36) and one instance of a basket hold for 3 minutes (individual #122). In the first case, documentation suggests that the release time was appropriate. In the second case documentation states "the restraint lasted 3 minutes due to the fact that I was losing my grip on her left wrist and decided that it be safer if we released her." There is no information on the restraint debriefing documents or progress notes as to the effect of this release on the individual's safety or staff safety. As noted in C1 there are a number of issues needing improved management oversight.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The Department of Aging and Disability Services (DADS) policy on restraint was completed on August 31, 2009. Review by the monitoring team found that the policy is congruent with and addresses relevant components of the settlement Agreement. RGSC has a well developed policy (SOP MR 700-14) governing use of restraints. It appears to address all topics called for in the DADS policy and the SA. It appears that the current RGSC policy has been in place for only a short time. Effective implementation, as noted in C1 above, is inconsistent suggesting the need for additional effective staff training and more effective mechanisms for managerial oversight.	
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	SOP MR 700-14 Section 1.D.10.a explicitly states "Use of restraint may only be authorized in response to behavioral crises that place the individual or others at serious harm, or, as a medical restraint." RGSC may wish to consider placing this policy statement at the beginning of the document to establish this as the overriding principle governing restraint	

#	Provision	Assessment of Status	Compliance
	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.	policy and procedure. In the review of specific restraint applications it was not always clear from the documentation that restraint was used as a crisis response, e.g., Individual #1 described in C1 where it appears restraint use may not have been necessary at all.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the	SOP MR 700-14 Section G.1 requires that a restraint monitor conduct and document an on-site 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 the consequences of the restraint. A limited record review indicates RGSC followed this policy. SOP MR 700-14 Section H.1.c requires that a clinically competent nurse, within 30 minutes or as soon as reasonably possible of the individuals release from restraint or of being told of the individuals release from restraint, conduct a face-to-face evaluation of the individual for injuries and overall well-being, including vital signs, respiration, circulation. This requirement also extends to situations where an individual is restrained away from the facility, requiring the assessment to occur within 30 minutes of return. A limited record review indicates RGSC followed this policy. Section H.1.c of the SOP does not explicitly require assessment to occur every 30 minutes as required by the SA. It should be noted that as a practical matter all restraints were of short duration, usually not more than several minutes. Nevertheless, the RGSC should comport to SA requirements. SOP MR 700-14 Section K.7.g requires that the written physician order for medical restraint include "specific assessment/monitoring frequency and rationale (at a minimum a patient is monitored every 2 hours)." Because the policy allows the physician up to 24 hours after the initiation of restraint to provide a written order, the assessment and monitoring instructions may be of limited value. This policy requirement needs to be strengthened. The review identified 2 instances for individual #47 where the documentation did not contain a post release assessment by an RN/LVN. From the limited review of records this was the only issue identified associated with the above requirements.	

#	Provision	Assessment of Status	Compliance
	individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.		
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	SOP MR 700-14 Section D.14 addresses each item referenced in the SA. When asking for restraint documentation relative to a specific episode, the monitoring team typically is provided the Restraint Checklist, the related Debriefing Form, and, if appropriate PSP addendums or other documents reflecting post restraint review and follow-up. The data elements required in this section of the SA are usually found in these documents. As noted in C1 (6) documentation for six restraint episodes was provided. In only one instance was a Restraint Checklist and Debriefing Form part of what was presented as documentation of the restraint episode. The restraint documentation provided to the monitoring team was primarily a computer generated report that included some of the data items found in a Restraint Checklist and/or Debriefing Form but was not complete as noted in the description of issues presented in C1.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:	SOP MR 700-14 does not address this topic. A review of restraint logs indicated there were no instances, other than medical restraint, where an individual was placed in restraint more than three times in a 30 day period. Therefore, there were no instances for assessment to determine whether provisions of the Settlement Agreement were met. Therefore, review of this provision will identify whether RGSC policy or procedures include each of the required elements. To ensure that documentation reflects implementation (that is, that the number of restraints reported match the number of restraints that actually occur), a larger sample will be reviewed, and interviews and observations will be conducted during future compliance reviews.	

#	Provision	Assessment of Status	Compliance
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	Based on the documentation provided it does not appear RGSC has an organized and effective process to accomplish this SA requirement.	
	(b) review possibly contributing environmental conditions;	SOP MR 700-14 Section D.14 addresses each item referenced in the SA. The restraint documentation provided to the reviewer did not include the specific elements required in C6. It may be RGSC staff did not understand the nature of the document request. At the first compliance review, the monitoring team will determine whether the documentation presented more accurately reflects practice.	
	(c) review or perform structural assessments of the behavior provoking restraints;	SOP MR 700-14 does not address this topic. A review of restraint logs indicated there were no instances, other than medical restraint, where an individual was placed in restraint more than three times in a 30 day period. To ensure that documentation reflects implementation, a larger sample will be reviewed, and interviews and observations will be conducted during future compliance reviews.	
	(d) review or perform functional assessments of the behavior provoking restraints;	Based on the documentation provided it does not appear RGSC has an organized and effective process to accomplish this SA requirement.	
	(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	SOP MR 700-14 Section D.14 addresses each item referenced in the SA. The restraint documentation provided to the reviewer did not include the specific elements required in C6. It may be RGSC staff did not understand the nature of the document request. At the first compliance review, the monitoring team will determine whether the documentation presented more accurately reflects practice.	

#	Pro	Assessment of Status	Compliance
	designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;		
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	SOP MR 700-14 does not address this topic. A review of restraint logs indicated there were no instances, other than medical restraint, where an individual was placed in restraint more than three times in a 30 day period. To ensure that documentation reflects implementation, a larger sample will be reviewed, and interviews and observations will be conducted during future compliance reviews.	
	(g) as necessary, assess and revise the PBSP.	Based on the documentation provided it does not appear RGSC has an organized and effective process to accomplish this SA requirement.	
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.	SOP MR 700-14 Section D.14 addresses each item referenced in the SA. The restraint documentation provided to the reviewer did not include the specific elements required in C6. It may be RGSC staff did not understand the nature of the document request. At the first compliance review, the monitoring team will determine whether the documentation presented more accurately reflects practice.	

Recommendations:

1. The RGSC's efforts to decrease the use of restraints should continue.
1. A considerable amount of additional training in all elements of RGSC SOP MR 700-14, including documentation requirements, needs to occur to ensure staff understand policy and procedure requirements, are able to articulate them to each other, and put them in practice.
2. RGSC may want to consider creating a reference tool that staff can use when they need a quick "refresher" on the most important "do's and don'ts" associated with restraint use.
3. RGSC needs to establish a QA mechanism that can effectively ensure that when a restraint event occurs all aspects of policy were followed and if not, initiate effective corrective follow-up.
4. RGSC policy needs to be revised to comport with the SA requirement of 30 minute nursing checks while a person is in restraint.
5. RGSC needs to consider aspects of MR 700-14 Section K.7.g that might strengthen the role of physician oversight with respect to medical restraint.
6. MR 700-14 needs to include a section that addresses the SA requirements enumerated in C7.
7. RGSC should strive be timelier in the production of tracking and trending data.

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:** Because this is a baseline review a comprehensive set of documents was reviewed to ensure proper identification of subject matter specific information. Similarly, a number of staff, particularly administrative staff, were interviewed on SA provisions relevant to Section C, D, E, and I. The following activities occurred to assess compliance: Review of the following documents: 1. DADS Policy #002.1 Protection from Harm – Abuse, Neglect, and Incident Management, dated 11/06/09. 2. DADS Policy #001: Use of Restraint, dated 8/31/09. 3. Health Care Guidelines, dated May 2009. 4. RGSC SOP MR 700-14 – The Use of Restraint. 5. RGSC SOP MR 200-1 6. Restraint records for individuals #1, #36, #47, and #122 7. PMAB Training Curriculum – restraint section 8. Client Files for individuals #5, #35, #79, and # 85 15. All documents referenced in baseline document request including but not limited to: a. incident and injury tracking logs b. restraint tracking logs c. general information about the RGSC. 9. Table of Contents of the RGSC Management Plan 10. Performance Improvement Council (PIC) report 11. Most current Trend Analysis Report 12. Sample Root Cause Analysis 13. Corrective Action Plans (CAP) for 6 most recent incidents 14. Daily Dorm Reports for 2/24/10 15. Incident Management Daily Review minutes for 10/5/09, 9/11/09,3/2/10 **People Interviewed:** 1. Sonia Hernandez-Keeble, Superintendent 2. Blas Ortiz, Assistant Superintendent 3. Mary Ramos, Quality Management Director 4. Bertha Lopez, Mental Retardation (MR) Services Program Director 5. Rosie Sanchez, Quality Enhancement (QE) Coordinator 6. Alondra Machado, Data Analyst 7. Megan Gianotti, Assistant MR Program Director 8. Dennis Provaznik, Incident Management Coordinator (IMC) 9. Myrna Wolfe, QMRP Coordinator

	10. Karina Serratos, Facility Investigator 11. Vina Guerrero, Training Director 12. Vicente Arismendi, Staff Trainer 13. Ray Ramos, Risk Manager 14. Eli Perez, DFPS Investigator 15. Direct care staff (6) **Meetings attended/Observations:** 6. Human Rights Committee meeting 3/4/10 7. Personal Support Team meeting 3/4/10 8. Discharge Planning meeting 3/2/10 9. Incident Management Team meeting 3/2/10 10. Living area observations, including observations of individuals receiving 1:1 supervision. Specific observations of Individuals #4, #27, #51, #82, #113, and #116
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor Assessment: The narrative below describes a series of fundamentally sound policies and, for the most part, acceptable practices in the area of protection from harm and incident management. RGSC needs to ensure it reviews data on allegations, investigations, and injuries in the ICF/MR component to determine trends. The most recent trend analysis (Quarter Ending 11/30/09) showed 21 allegations of abuse/neglect with 17 being allegations of abuse. An average of seven allegations a month for an organization serving 71 individuals indicates a need for review by the Facility. Of the 17 allegations of abuse, 13 were allegations of physical abuse with eight of the 13 unconfirmed through investigation. The other five were either confirmed (2) or found to be inconclusive (3). Inconclusive can mean that abuse is suspected but there was insufficient evidence or lack of witness corroboration to state a definitive conclusion. Again, confirming or partially confirming over one-third of the allegations of physical abuse indicates a need for review by the Facility. Facility leadership would be well served to engage in some thought provoking discussion of this topic. It was observed that many meetings the reviewer was scheduled to attend started late. This may have been because of last minute location changes or merely due to a certain amount of disruption inherent in these reviews. Nevertheless, chronic patterns of late starting meetings can be a sign of lack of focus on organizational mission. RGSC has the beginning elements of a good quality assurance and incident management system in place. In reviewing various documents, and from interviews, it was not clear that intended follow-up was necessarily occurring as planned. Location of certain documents and questions about who holds the "official file" often elicited confusing responses. Description of various work processes often got more confusing as questions were asked to clarify a work process. For now this might be explained by all the recent change at RGSC to position itself to comply with the SA. Presumably, future reviews will find information better organized, less confusing, and easier to understand.

	PNAs interviewed were generally knowledgeable of basic responsibilities including abuse and injury policy and procedure. For the most part, however, they had limited knowledge of PSP provisions, active treatment requirements, training and support they receive, and positive behavior supports. PNAs often use terms for things that are different than official terms. When asked about a particular form (using its official title) they may not recognize the name. When a description of what the form was used for was provided by the reviewer they usually were able to recognize that form using their own term for that form. Additional effective staff training is needed.

#	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 DADS policy on abuse, neglect, and incident management was completed on November 6, 2009. The monitoring team reviewed the policy and it was found to correspond in most respects to what is required under the Settlement Agreement. Any variations from the SA are noted under the corresponding sections below. The DADS abuse, neglect, and exploitation rules and incident management policy state that abuse, neglect, and exploitation are prohibited. The SSLC's are required to comply with these State policies and rules. RGSC policies and procedures on abuse, neglect, and Incident Management also were reviewed. They are embedded in the RGSC Standard Operating Procedure MR 200-01. This policy was established in December 2009 and last revised in January 2010. The policy statement at the front of this document does not state a prohibition against abuse, neglect, and exploitation (this is covered in the next section of the document under the label "Procedure"). The statement labeled "Policy" reads "any incident/situation which has harmed or may potentially harm a resident shall be immediately identified, reported, reviewed, investigated, and corrected." To reflect the intent of the SA, intolerance of A/N/E should be stated in a firm and unequivocal manner at the very beginning of the policy. SOP MR 200-01 describes a comprehensive set of activities including staff training, protection for residents, notification responsibilities, prohibition against retaliatory action, temporary work reassignment of alleged perpetrators, the process for facility based investigations, the process for review and disposition of reports from the Department of Family and Protective Services (DFPS) and DADS Regulatory, incident management coordination, and data tracking, analysis, and corrective action. Not included in SOP MR 200-01 is a process for the review of non-serious injuries for review or investigation to rule out abuse or neglect as a cause or contributory cause. This	

#	Provision	Assessment of Status	Compliance
		process should include an element that requires a review of injuries of known cause (witnessed and where a probable cause hypothesis has been developed) to ensure reasonable and defensible judgments are being made as to the credibility of the person who witnessed the event leading to an injury, and, the credibility of the probable cause hypothesis. While the RGSC has a process to address some aspects of this it should be reflected in the Center's major policy on Protection from Harm. It is important that non-serious injuries receive a level of investigatory scrutiny sufficient to allow a reasonable judgment that abuse or neglect was not a factor in the possible cause of the injury.	
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:	DADS Policy 002.1 Protection From Harm - Abuse, Neglect, and Incident Management, dated 11/6/09 addresses this section of the Settlement Agreement. RGSC SOP MR 200-1 describes the facility policies, procedures, and practices designed to ensure SA compliance as well. Both policies appear to include most of the essential elements required in the SA. Through documentation review, interview, and observation a number of issues were identified as described in sections a-i below.	
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	SOP MR 200-01 Section IV.A.1 requires immediate (and in no case more than one hour after suspicion or after learning of the incident) notification to DFPS of any suspected act of abuse, neglect, or exploitation. This policy also requires immediate notification of the Superintendent, or designee, in order to begin the process of implementing client protection measures, securing evidence where appropriate, beginning an investigation and any other administrative actions deemed appropriate to the circumstances. A review of a sample of incident reports did not reveal issues with timeliness of reporting. The daily meetings of the Incident Management Team and the comprehensiveness of the Daily Dorm Report appear to be effective mechanisms to quickly identify any issue that should have been reported and wasn't and to examine causation factors if any incident was reported late.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect,	SOP MR 200-01 Section III requires immediate steps that must be taken to protect individuals, assess injury, secure evidence, and remove the alleged perpetrator from the scene. The policy does not, however, explicitly state an alleged perpetrator must be	

#	Pro	Assessment of Status	Compliance
	exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	reassigned to not have contact with any individuals (although a review of the incident management process and incident reports indicates this is in fact the practice at RGSC). The policy in this section states the alleged perpetrator be "removed from contact with the resident" leaving open the question of his/her ability to be reassigned to another work area working with a different set of individuals. In Section VI there is a clearer statement that says the alleged perpetrator is forbidden to have any contact with clients. RGSC may want to revise this policy to remove any ambiguity. Section VI of this policy contains behaviorally oriented requirements directed at reassigned staff to ensure they cooperate and do not interfere with the investigation. A review of a sample of incident reports, observation of the Incident Management Team meeting, and staff interviews confirm that alleged perpetrators are always reassigned away from client contact job responsibilities. The Facility Investigator, Incident Management Coordinator, and the DFPS Investigator reported that for the most part staff cooperate with their investigations. No one interviewed could point out any specific examples of noncooperation or acts that would compromise an investigation.	
	(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.	SOP MR 200-01 Section II requires all staff to attend competency based training on preventing and reporting abuse and neglect pre-service and every twelve months, It also requires that supervisors will periodically assess employee knowledge and provide additional training as needed. From staff interviews it was evident that the degree of clarity in understanding the abuse and neglect policy varied. Some staff provided the correct responses immediately. Some responded cautiously as if they weren't absolutely sure of what they were saying, and, one staff gave a response that would be considered inadequate. RGSC may want to consider a mechanism where staff routinely are asked questions about the A/N/E policy, perhaps in the context of administrative and supervisory rounds.	
	(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	SOP MR 200-01 Section II requires all staff to attend competency-based training on preventing and reporting abuse and neglect pre-service and every twelve months. A review of the curriculum confirmed that relevant and appropriate topics are covered in the training. The policy also requires that supervisors periodically assess employee knowledge and provide additional training as needed. As stated in D2c a more effective process for this work effort is warranted.	

#	Pro	Assessment of Status	Compliance
	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.	Policy requirements associated with this provision could not be located in SOP MR 200-01 or any other documents reviewed. This SA agreement requirement will be examined more closely at the next visit.	
	(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.	At the State level the DADS policy on abuse, neglect, and exploitation did not appear to require a rights posting nor could such a requirement be found in RGSC policy. A "You have the Right" poster was in display throughout RGSC; however, there were instances were it could have been more prominently displayed and made more eye-catching by using brightly colored paper or some other mechanism to make it stand out.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	SOP MR 200-01 Section IV.D requires immediate notification of law enforcement for "any suspicion of criminal activity." Since many acts of abuse, and many acts of neglect, would be suspicious of criminal activity most incidents, according to this policy, should be reported to law enforcement. They are not. This policy needs to be examined and clarified. Through interview and document review it was evident that certain incidents get referred to law enforcement, usually the state Office of Inspector General. Because of the ambiguity of the policy it was not clear what criteria, if any, were used to determine whether a law enforcement referral was warranted.	
	(h) Mechanisms to ensure that any	SOP MR 200-01 Section V prohibits retaliation and gives someone who feels they are	

#	Provision	Assessment of Status	Compliance
	staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	being retaliated against four avenues outside the RGSC chain of command to report whether or not they feel there concern is being adequately addressed at the center level. Policy also is clear that anyone found to have engaged in retaliatory action is subject to disciplinary action. This policy could be strengthened by including in those people covered against retaliation not just "an employee who reports an allegation" but also anyone who might have witnessed an incident and/or becomes a witness or is otherwise involved in an official investigation. Through interview RGSC staff claimed they were unaware of any specific instances of retaliation; however, the cautious nature of their responses dictates the need for further examination of this topic in future reviews. The DFPS investigator, when interviewed, was clear in his opinion that retaliatory acts were occurring, specifically mentioning vandalism towards automobiles. RGSC may want to initiate what amounts to a public relations campaign with its employees to ensure everyone is aware of the multiple avenues that can be pursued if one feels they are a victim of retaliation and that staff understand the consequences of participation in a retaliatory act or withholding information regarding a coworker.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	SOP MR 200-01 did not contain any elements to address this requirement of the SA. SOP MR 400-01 (Injuries to Consumers) also did not contain any elements to address this requirement of the SA. The QA Director acknowledged the need to get this activity organized and underway.	
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:	DADS Policy 002.1 Protection From Harm - Abuse, Neglect, and Incident Management, dated 11/6/09 addresses this section of the Settlement Agreement. RGSC SOP MR 200-1 describes the facility policies and procedures designed to ensure SA compliance as well. Both policies appear to include most of the essential elements required in the SA. Through document review, interview, and observation a number of issues were identified as described in sections a-j below.	
	(a) Provide for the conduct of all	State policy requires both DFPS and Facility Investigators to have training in	

#	Provision	Assessment of Status	Compliance
	such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	investigations. The policy does not make it clear that both DFPS and Facility Investigators must have training in working with people with developmental disabilities. It is also not clear that the investigations must be carried out by persons who are outside the direct line of supervision of the alleged perpetrator. RGSC policy (MR200-01) does not address qualifications of investigators or the need to ensure that investigators are outside the direct line of supervision of the alleged perpetrator. There is some question as to the organizational location of the Incident Management Coordinator (IMC) who supervises investigations and the work processes in place to review the work of the investigations unit. The IMC reports to the MR Services Director who directly supervises the staff who supervise the residential staff. This arrangement leads to questions regarding the SA agreement requirement prohibiting an investigator being in the direct line of supervision of an alleged perpetrator. In a technical sense the IMC is not in the direct line of supervision of residential staff. However, since he is supervised by the same person who supervises residential staff there is potential for a conflict of interest on the part of the MR Director who would be in a position to adjudicate differences of opinion between investigation findings that impact her staff. Please note that the monitoring team did not find any evidence of this and is only pointing this out as a potential issue the Center leadership may wish to examine more closely. When queried on this topic, the Superintendent and Deputy Superintendent pointed out that the work of the investigation unit is routinely checked by the Risk Management Director who is clearly outside the line of supervision for residential services. Both felt this served as a quality control process to ensure the integrity of the investigatory process. Upon interviewing the Risk Management Director, and reviewing some of the same documents he reviews, it was evident his documentation does not contain enough information to adequately assess whether an investigation was thorough, complete, and came to reasonable conclusions. It appeared most of this work activity was to ensure a particular form contained all the proper data elements. In most facilities the common practice is for the investigation unit to report to a part of the organization that is clearly separate from line authority over residential and vocational services. The most typical models have the investigation unit reporting to Quality Assurance or the Facility Director. RGSC does not appear to have any written protocol for the conduct of an investigation. While not a requirement of the SA, written investigation protocols represent good practice and are extremely useful for staff investigators with limited experience. It appears investigators are sent for training by an outside organization and are expected to return to the facility ready to conduct investigations.	
	(b) Provide for the cooperation of	Policy contained limited information addressing the topic of staff cooperation with	

#	Provision	Assessment of Status	Compliance
	Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	outside investigators. Most was in regard to the person being investigated. From interviews of RGSC staff and DFPS it is clear a high degree of cooperation exists. This is due in part to the fact the DFPS investigator has been assigned to RGSC for a number of years and had previously worked at RGSC. Based on a review of a limited number of investigation reports there was no indication that RGSC had failed to cooperate with investigations conducted by DFPS or OIG.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	DADS policy Section V.D refers to reporting to law enforcement. SOP MR 200-01 Section IV.D also refers to reporting to law enforcement; however, as discussed earlier the ambiguity of what constitutes "suspicion of criminal activity", in the context of abuse and neglect, needs to be addressed through policy revision. Document review confirmed multiple instances of incidents being referred to law enforcement (OIG).	
	(d) Provide for the safeguarding of evidence.	SOP MR 200-01 contains very little information or direction regarding the safeguarding of evidence. Policy revision is needed to address specific methods for safeguarding evidence including things as specific locations for storage of physical evidence, how it is to be stored, who has key access to the storage location, and how the chain of custody is documented. Based on a review of a limited number of investigation reports (both internal and DFPS) there was no indication that any investigation was affected because of problems with safeguarding evidence.	
	(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	The term "Serious Incident" is not explicitly defined in SOP MR 200-01, Policy requires allegations of abuse or neglect to be reported to DFPS within one hour of discovery of the incident or knowledge of the incident. Policy requires incidents reportable to DADS regulatory to be reported within 24 hours of occurring or being reported (this covers serious injuries which are defined in policy). Policy also requires that investigation of serious incidents commence within 24 hours or sooner. Policy further requires that the facility must complete its investigation of "a significant incident within 14 calendar days (10 calendar days after June 1, 2010) of the incident being reported. The definitions section of SOP MR 200-01 also does not provide a definition of significant incident. The lack of an explicit definition of what constitutes a serious incident and a significant incident may lead to confusion or misunderstanding regarding these time constraints. Policy revisions should occur to address this.	

#	Pro	Assessment of Status	Compliance
	summary of the investigation, findings and, as appropriate, recommendations for corrective action.	A review of a limited number of incident reports confirmed that the timelines called for in RGSC policy are, for the most part, being followed. Timeliness of reporting will need to be tested in future reviews.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	SOP MR 200-01 Section VIII.H provides specific requirements associated with investigations conducted by RGSC staff. In reviewing DFPS Investigation Reports it is obvious they use a similar approach in conducting investigations. Each use a standardized format in report presentation. Allegations of abuse, neglect, and exploitation are investigated by DFPS. Based on a review of a limited review of DFPS investigation reports DFPS appears to be, for the most part, thorough in their investigation and produces reports that contain the elements called for in the Settlement Agreement. In an interview with a Unit Director the topic of a DFPS "streamlined investigation process" came up. It could be used in instances where an incident reporter is viewed as a chronic reporter whose claims are always unfounded, and, whose motive in reporting is apparently attention seeking. The status of this streamlined process was unclear (that is, whether a planning process has been put in place, and, if so, what elements of a complete investigation would be removed in order to have a streamlined investigation). If this is going to be pursued, there should be safeguards developed that establish clear (and legal) reasons why and under what circumstances one individual gets reports "completely investigated" and another gets only a "streamlined investigation," along with any criteria that always call for a full investigation. Such a practice has clear implications in the area of rights as well as implications in the ICF/MR compliance requirement of "complete and thorough" investigations.	
	(g) Require that the written report, together with any other relevant documentation, shall	SOP MR 200-01 Section X requires that the RGSC Review Authority review final DFPS reports and make recommendations to the Director or designee within two working days of receipt. Section VIII.J provides that RGSC based investigations of incidents be	

#	Provision	Assessment of Status	Compliance
	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.	presented by the facility investigator to the Incident Management Coordinator within 5 working days of the incident. The IMC is then to make a final presentation to the Incident Management Team although policy does not state a timeframe for this to occur or what the expected outcome of this presentation is to be. A limited review of investigation reports confirmed the above process occurs and included documentation that RGSC follows up with DFPS whenever questions or ambiguity emerge in the review of a specific investigation. This included RGSC initiating an internal follow up investigation to pursue issues it felt were not adequately probed by the DFPS investigator.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The limited sample of reports reviewed indicates that the reports accurately depict the event, the investigatory process, the outcome, and expected follow-up.	
	(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 limited sample of reports reviewed indicates implementation of actions determined to be needed by the Incident Management Team were initiated by the IMC and tracked. The IMC has developed several tools for his use in this tracking process. Documentation was not always present in the IMC file to confirm completion and filing was not current making a file audit difficult. The one incident file randomly pulled in the IMC office lacked documentation for some follow-up activity. The IMC stated he is behind in filing and pointed to a stack of paper on his desk. He indicated most of the documents needing to be filed were responses from others at the facility regarding follow up that had been completed.	
	(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.	A review of investigation files maintained in the IMC's office confirmed a well organized system for maintaining files and making them accessible, however, the IMC indicated he was behind (several months) in keeping files current. This would consist primarily of documentation regarding follow-up actions directed by the Incident Management Team (IMT). From interview it was initially unclear if the files maintained by the IMC were considered, by RGSC, to be the "official file" for each incident. This was eventually confirmed. There were other instances where the reviewer had a difficult time determining whether what was provided was an "official" record, document, or file. This suggests a need for all staff at a management level to be able to distinguish between what may be someone's working file, or individual work product, from a document or record that would be considered as an official file.	
D4	Commencing within six months of the Effective Date hereof and with	SOP MR 200-01 Section XIII.H contains the requirements for tracking and trending that will enable this element of the SA to be met. At the present time this data collection and	

#	Provision	Assessment of Status	Compliance
	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.	how analysis would lead to future decision-making is in its early stage of development. Some of the tracking and trending that has occurred is yielding information which merits considerable discussion at the facility leadership level. One area is the abuse/neglect topic discussed at the beginning of this section. Another area is the tracking data on client injuries. The monitoring team looked at the most recent Trend Analysis Report (November, 2009) and summarized injury data for the 11 most recent months. During this 11 month period there were a total of 936 injuries (85 per month). This is a rate of 1.2 per client. This is on the high end of the range typically found in similar settings. The good news is most injuries required no medical treatment. Only 11 of the 936 were rated serious, and another 200 were rated non-serious. The Trend Analysis Report has reporting categories for serious injuries, non-serious injuries, no treatment required injuries, and, no injury apparent. There is a concern as to the source of these data. The RGSC Injury Policy (SOP MR 400-01) does not delineate four categories of injury classification nor was it apparent on any other injury reports viewed during the tour.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	The State policy on Abuse, Neglect and Exploitation does not contain information on prerequisites to allowing staff or volunteers to work directly with individuals. Section 3200.3 of the DADS regulations on Volunteer Programs requires criminal background checks on volunteers. The DADS Operational Handbook, Revision 09-21 effective 10/29/09 (Section 19000 Part E) requires criminal background checks on employees. The DADS criminal history rule also contains prerequisites for allowing staff or volunteers to work directly with individuals. Interviews confirmed these checks take place. File verification will occur in future visits.	

Recommendations	**Recommenda**
1. Revise RGSC abuse and neglect policy to clearly articulate intolerance of A/N/E in a firm and unequivocal manner at the very beginning of the policy . 2. Establish a process for the review and/or investigation of non-serious injuries to rule out abuse and neglect. 3. Establish a process by which staff are regularly queried as to their understanding of abuse and neglect policy, reporting requirements, retaliation prohibition, etc. 4. Establish a quality assurance process that audits incident reports. 5. Examine policy on law enforcement referral of incidents leading to less ambiguous criteria for referral. 6. Establish a process for audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation. 7. Examine organizational placement of the investigations unit and/or establish additional safeguards to protect the integrity of investigation outcomes. 8. Revise RGSC policy to include provisions for safeguarding evidence with respect to incidents. 9. Revise policy to provide a definition of the term "serious incident" as used in the Settlement Agreement. 10. Requirements about training of investigators should be included in the DADS' policy on Abuse/Neglect/Exploitation, or if these requirements are elsewhere in State policy, reference to their location should be provided in the A/N/E policy. The DADS' policy also should include requirements that the Facility Investigator be outside the direct line of supervision of the alleged perpetrator.	

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;** Because this is a baseline review a comprehensive set of documents was reviewed to ensure proper identification of subject matter specific information. Similarly, a number of staff, particularly administrative staff, were interviewed on SA provisions relevant to Section C, D, E, and I. The following activities occurred to assess compliance: **Documents Reviewed:** 1. DADS Policy #002.1 Protection from Harm – Abuse, Neglect, and Incident Management, dated 11/06/09. 2. DADS Policy #001: Use of Restraint, dated 8/31/09. 3. Health Care Guidelines, dated May 2009. 4. RGSC SOP MR 700-14 – The Use of Restraint. 5. Restraint records for individuals #1, #36, #47, and #122 6. PMAB Training Curriculum – restraint section 7. Client Records for individuals #5, #35, #79, and # 85 8. All documents referenced in baseline document request 9. Table of Contents of the RGSC Management Plan 10. Performance Improvement Council (PIC) report 11. Most current Trend Analysis Report 12. Sample Root Cause Analysis 13. Corrective Action Plans (CAP) for 6 most recent incidents 14. Daily Dorm Reports for 2/24/10 15. Incident Management Daily Review minutes for 10/5/09, 9/11/09,3/2/10 16. RGSSCL Medical/POI QA Audit Tool, December, 2009 17. RGSSCL Nursing Monthly Staff Meeting Minutes, July through December, 2009 **People Interviewed:** 1. Sonia Hernandez-Keeble, Superintendent 2. Blas Ortiz, Assistant Superintendent 3. Mary Ramos, Quality Management Director 4. Bertha Lopez, MR Services Program Director 5. Rosie Sanchez, QE Coordinator 6. Alondra Machado, Data Analyst 7. Megan Gianotti, Assistant MR Program Director 8. Dennis Provaznik, Incident Management Coordinator 9. Myrna Wolfe, QMRP Coordinator 10. Karina Serratos, Facility Investigator 11. Vina Guerrero, Training Director 12. Vicente Arismendi, Staff Trainer 13. Ray Ramos, Risk Manager

	14. Eli Perez, DFPS Investigator 15. Jessica Juarez, RN, Quality Assurance Nurse 16. Direct care staff (6) **Meetings attended/Observations:** 1. Human Rights Committee meeting 3/4/10 2. Personal Support Team meeting 3/4/10 3. Discharge Planning meeting 3/2/10 4. Incident Management Team meeting 3/2/10 5. Living area observations, including observations of individuals receiving 1:1 supervision. Specific observations of Individuals #4, #27, #51, #82, #113, and #116
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor Assessment: RGSC has many elements of a Quality Assurance plan in place or under development**.** Much of what is in place grew from systems in place to comply with the MI section of the organization. Care will need to be taken to ensure plan elements for the MR section are specific to MR requirements. At this point RGSC's major task is the development of a comprehensive and detailed quality assurance plan that meets all the requirement of state policy. Equally important, is to assess the systems they now have in place, including the data collected, aggregated, and trended and determine how best to use it for future planning and decision-making. The facility had few monitoring systems in place to assess nursing care and clinical outcomes The Quality Assurance nurse had recently developed and implemented a Medical/POI QA Audit Tool designed to meet the SA and HCGs for Sections: G - Integrated Clinical Services, H – Minimum Common Elements of Clinical Care, J – Psychiatric Care and Services, L – Medical Care, M – Nursing Care, N – Pharmacy, O – Physical and Nutritional Management, and Q Dental Service. A threshold of 100% was established for compliance. However, it did not evaluate the quality of care or make recommendations for corrective actions. Many nursing practices requiring corrective action were included in the Nursing Staff Monthly Meeting minutes, July through December, 2009: compliance issues were identified and discussed; recommendations for corrective actions made; responsible staff assigned to tasks; and, date for completion. Issues that required follow up through resolution were not consistently reported in the subsequent monthly meeting minutes. In addition, no documentation was found analyzing effectiveness of corrective actions or interventions implemented.

#	Provision	Assessment of Status	Compliance
E1	Track data with sufficient particularity to identify trends across, among, within and/or	The monitoring team's review of the State Policy with regard to quality assurance/enhancement showed that it was consistent with the requirements of the Settlement Agreement. The facility has not yet developed a Quality Assurance Plan which	

#	Provision	Assessment of Status	Compliance
	regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	would direct activity and assign responsibilities for its various elements. In response to the document request for the Quality Assurance Plan, the RGSC SOP QM 100.014 was provided. This document was merely a restatement of DADS requirements for quality enhancement expectations and lacked the organizational and operational specificity called for in a QA plan that includes multiple processes that yield reliable data that can stimulate organizational improvement. RGSC does produce a Quarterly Trend Analysis and a more detailed quarterly Individual Injury Trending document. It is unclear how the facility leadership uses this information to identify systemic issues and determine needed changes in policy and procedure. It is clear the data are not compiled timely. The next report for the quarter ending 2/28 was scheduled for 3/24. The most recent month on the available report was 11/09. This does not allow for timely identification of emerging issues. RGSC is using its Plan of Improvement (POI) process to monitor some elements of the SA and has in place a Quality Enhancement Corrective Action Plan Tracking System form and a DOJ Plan of Improvement Corrective Action Plan Reporting Document form. While there was evidence that these two processes are in place there was not evidence that it is developed to the point where the data gathered can be used to identify and address systemic issues. RGSC also has an Improving Organizational Performance Plan. This document is geared to the MI part of the organization but does provide a template of sorts that could be used to structure a QA plan for the DD side of the organization. It, too, lacks sufficient specificity with respect to what gets measured, by whom, at what frequency, and what happens as a result. It should, therefore, not be considered a model for a DD QA plan but perhaps a starting point in the development of a plan. The facility had few monitoring systems in place to assess nursing care and clinical outcomes at the time of the monitor team's review. RGSC has a Quality Assurance nurse (QA) who recently developed and implemented a Medical/POI QA Audit Tool designed to meet the SA and HCGs for Sections: G - Integrated Clinical Services, H – Minimum Common Elements of Clinical Care, J – Psychiatric Care and Services, L – Medical Care, M – Nursing Care, N – Pharmacy, O – Physical and Nutritional Management, and Q Dental Service. A threshold of 100% was established for compliance. The Medical/POI QA Audit Tool was completed for the December, 2009 review period and was used for the review of three records for the above sections. The comment section of the audit tool described causes of compliance failures; however, it did not evaluate the quality of care or make recommendations for corrective actions. Audit reports were given to the respective discipline for follow-up and corrective action. The facility needs to cross-walk the	

#	Provision	Assessment of Status	Compliance
		recently developed audit tool with the SA and HCGs to ensure that all areas required for compliance are addressed. The tool also needs to address quality of care provided by clinical disciplines and make recommendations for corrective action. The QA department needs to analyze, track and trend clinical performance data to identify areas of practice to ensure non-compliant practices demonstrates improvements. Many nursing practices requiring corrective action were included in the Nursing Staff Monthly Meeting minutes, July through December, 2009: compliance issues were identified and discussed; recommendations for corrective actions made; responsible staff assigned to tasks; and, date for completion. Issues that required follow up through resolution were not consistently reported in the subsequent monthly meeting minutes. In addition, no documentation was found analyzing effectiveness of corrective actions or interventions implemented. As nursing develops and implements additional monitoring tools and generates additional clinical data, the Nursing Staff Meeting minutes need to include significant findings from these tools making it a succinct document. The nursing staff needs to develop and implement a system to analyze, track, and trend data that identifies areas where nursing practices needs improvement. Two subject areas did not appear to be included in any of the QA material reviewed. These are in the area of habilitation outcomes and behavior management effectiveness. These are obvious two key indicators for the quality of life for individuals living at RGSC.	
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.	Through document collection and interview there is some evidence that corrective action plans (CAPs) are developed when Plan of Improvement (POI) activities identify issues that need to be addressed. Those CAPs reviewed tended to address specific issues and not systemic problems. RGSC needs to develop a mechanism to figure out if these individual problems can be tied to some systemic issue such as a policy that doesn't adequately address a topic, or, procedural processes that are letting certain things go unnoticed. RGSC has a system in place to track incident and injury data. Data are being tracked and trended by type of incident, staff involved, clients involved, incident location, day of week and time, shift, cause, & investigation outcome. This is a very good start to an effective system for collecting and aggregating performance related data. Non-serious injuries are not tracked and trended although the Trend Analysis Report for the 1st Quarter, FY 2010 did contain a discussion on non-serious injuries. Non-serious injuries should be included in a tracking and trend system designed to identify and remedy situations that can become unsafe for individuals. Also, it is often the case that a	

#	Provision	Assessment of Status	Compliance
		series of certain types of non-serious injuries can be an indicator of possible abuse or mistreatment that would need to be addressed. RGSC has a system in place to identify problems and plan corrective action. There are daily unit based meetings to discuss a wide range of issues from the last 24 hours including injuries, incidents, individual health concerns, hospitalizations, and environmental concerns. These concerns are comprehensively documented on the Daily Dorm Report. .	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	There is evidence that corrective action plans were disseminated. This will be reviewed in future visits.	
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.	There is evidence that corrective action plan implementation is monitored for completion. There is little analysis as to the prospective impact that corrective action has in reducing future problems caused by the similar contributing variables. This will be assessed further in future reviews.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	There is limited evidence that corrective action plans are modified, primarily because those reviewed were so simple to implement there would not be a need for modification. It would be expected that as the QA process develops and matures the nature of problems identified, and the resultant corrective action plans, would become more complex and require periodic modification to ensure they continue to adequately address whatever problem they are designed to address.	

Recommendations:

1. RGSC needs to develop a comprehensive QA plan for MR services that includes all the elements contained in State policy, including review tools to be used, schedules for monitoring, processes for analyzing data, identifying trends, and developing, implementing, and monitoring corrective action plans. The roles of other departments and staff in the QA monitoring process as well as the implementation of corrective action plans should be defined.
2. RGSC needs to develop a QA plan implementation strategy as it is unlikely all elements of a comprehensive plan can be launched simultaneously.
3. RGSC needs to assess the viability of producing existing trend data reports sooner than the current timeframe so they can be more useful to current decision-making.
4. RGSC needs to develop strategies as to how QA data can be used to assess organizational performance and used to stimulate change that will, over time, improve organizational improvement.

5. The Facility needs to cross-walk the recently developed nursing audit tool with the SA and HCGs to ensure that all areas required for

compliance are addressed. The tool also needs to address quality of care provided by clinical disciplines and make recommendations for corrective action. The QA department needs to analyze, track and trend clinical performance data to identify areas of practice to ensure non-compliant practices demonstrate improvements.

6. As nursing develops and implements additional monitoring tools and generates additional clinical data, the Nursing Staff Meeting minutes need to include significant findings from these tools making it a succinct document. The nursing staff needs to develop and implement a system to analyze, track, and trend data that identifies areas where nursing practices needs improvement

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:** **Documents Reviewed:** 1. Health Care Guidelines, dated May 2009. 2. RGSC SOP MR 700-14 – The Use of Restraint. 3. RGSC SOP 600 01 Person Directed Planning, dated July, 2003 4. RGSC SOP 600 02 Development and Monitoring of Individual Program Plans, Person Directed Approach, dated September, 1992 5. Person Directed Planning Process Slide Presentation 6. Personal Focus Worksheet 7. Person Directed Planning Training Assessment form 8. Client Record for individuals #5, #35, #79, and # 85 9. All documents referenced in baseline document request 10. Most current Trend Analysis Report 11. Daily Dorm Reports for 2/24/10 12. HRC minutes (undated) 13. PSP Monitoring Checklist Individual #77 14. PSP for Individual #77 1/20/10 15. PSP for Individual #108 3/4/10 16. QSO Scoring Guide Person Directed Planning Process 12/09 17. PALS (Positive Assessment of Living Skills) Handbook 18. Comprehensive Functional Assessment – Active Treatment Assessment (POR-MR-21) document 19. Consumer Support Observation and Interview from 2/24/10 20. Personal Focus Worksheet: Individualized Assessment Screening Tool for Individuals # 5, 8, 54, 77, and 126. 21. RGSC Policy MR 600 01 Person Directed Planning dated July, 2003 22. ME Books for Individuals #4 and #19 **People Interviewed:** 1. Mary Ramos, Quality Management Director

	2. Bertha Lopez, MR Services Program Director 3. Megan Gianotti, Assistant MR Program Director 4. Myrna Wolfe, QMRP Coordinator 5. Direct care staff (6) **Meetings attended/Observations:** 1. Human Rights Committee (HRC) meeting 3/4/10 2. Personal Support Team (PST) meetings 3/4/10 for Individuals #77 and #108 3. Discharge Planning meeting 3/2/10 4. Living area observations, including observations of individuals receiving 1:1 supervision. Specific observations of Individuals #4, #27, #51, #82, #113, and #116
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor Assessment: RGSC SOP MR 600-01 (Person Directed Planning) and MR600-4 (Personal Support Plan Addendums) were provided to the monitoring team in response to the document request asking for documents, policies, and procedures addressing the development and implementation of individualized plans. Form POR-MR-80 (Personal Support Plan) and its instructions were also provided. RGSC has been using the above PSP format as required by DADS and dated 10/26/09. The current PSP process, as implemented, meets some of the technical requirements of the Settlement Agreement(SA); however, most of the elements required in Section F were either not developed or not thoroughly implemented, making substantive baseline assessment difficult. The monitoring team is aware this format, and accompanying instructions, are subject to a significant modification and that a statewide workgroup is being convened in April, 2009 to develop a PSP policy that will refine the PSP process in a manner intended to facilitate compliance with the SA. Comments in this section are limited because of this. Overall, through document review, interview, and meeting observation there was little evidence of departments and disciplines coming together throughout the year, and in anticipation of the annual PSP planning process, to assess individual needs and develop service strategies in an integrated manner.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in	The PST meetings are facilitated by an assigned QMRP. The meetings consist largely of individual team members reading or summarizing reports with little substantive discussion across disciplines. This lack of integrated planning witnessed at PSP meetings seems to translate to a lack of integrated service delivery in day to day operations. An example of this	

#	Provision	Assessment of Status	Compliance
	developing, monitoring, and revising treatments, services, and supports.	lack of integration follows. Issues were found regarding the transfer and timely implementation of recommendations when an individual returns home from the hospital. PNMPs, Nursing Care plans, and risk screenings are not always revised in a timely manner in response to a change in status. For example: • Individual #42634 returned from the hospital on 11/24/09 with a g-tube but the PNMP was not revised until 12/29/09. • Individual #42634 was placed on enteral nutrition on 11/24/09 however the nursing care plan 12/17/09 states that he still receives food by mouth. The care plan was not revised until 2/22/10. • Individual #42634 risk screenings were not updated until 1/4/10 although there was a significant change in status at the end of November 2009. • Recommendations were for Individual #42634 to remain at 45 degrees when in bed at all times, however this was not integrated into his plans.	
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.	RGSC SOP 600 01 Person Directed Planning provides a good statement of philosophy and practice. In practice, although most required actions are present during planning, they do not guarantee either a person-directed process and outcome or an integrated planning process. From record review, interview, and meeting observation it was not always clear who was expected to participate in an individual's annual PSP meeting. In reviewing individual #77's annual ISP meeting (1/20/10) there were 10 people present (in addition to the individual); however, there is no indication that a LAR was present and there was no PNA present.. At the PSP meeting for Individual #108, a Psychiatric Nurse Assistant (PNA) was present. The lack of PNA presence suggests a lack of a substantive role in the PSP process for PNAs. When the individual became restless, the PNA took the individual and left; she remained away from the meeting for an extended time until the QMRP called to ask her to return. PNAs interviewed during the tour provided a variety of responses as to their input into PSP processes, their participation in planning meetings, and any regular communication they had with non-unit based staff (primarily clinical) about the needs, services, and supports of the people they worked with. Most responses reflected a lack of regular and substantive dialogue.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient	The example described in F1a suggests the problematic nature of compliance with this element of the SA. It is hoped that the new state policy will provide direction regarding the type and frequency of assessments and how different disciplines need to collaborate and problem solve in developing service strategies for individuals. The absence of sound	

#	Provision	Assessment of Status	Compliance
	quality to reliably identify the individual's strengths, preferences and needs.	policy direction in this area resulted in QMRP's following typical procedures such as team members reading reports followed by little or no discussion and team collaboration. The appearance to the reviewer was that a meeting was taking place because it was required, not because it was intended to impact the individual's life.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	There was little evidence that a systematic process was in place to ensure assessment results were incorporated into the development and implementation of integrated program planning for the individual. There was little evidence of any cross communication between disciplines. The absence of regular substantive interdisciplinary discussion, and, the quality of assessments and evaluations (e.g. nursing and physical management) referenced elsewhere in the report are significant barriers to compliance with this element of the SA.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	While no overt areas of noncompliance with ADA and Olmstead were observed it will be important for the new state policy to address in detail how provisions of ADA and Olmstead are expected to be operationalized in PSP planning. Please note comments about the Living Options Discussion Record in Section T below.	
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:	The PSPs reviewed, and the meetings attended, discovered little discussion or activity in most of the seven areas. Clearly, more definitive policy direction is needed to ensure progress in this area of the SA. The PSP document did contain some required elements as noted 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,	The PSP document includes sections on "What's Most Important to the Person?" and "How Is This Supported?", This information is a start but it was difficult to find information in PSPs that used this information to prioritize needs, increase community participation, and develop supports needed to eliminate barriers.	

#	Provision	Assessment of Status	Compliance
	identifies the supports that are needed, and encourages community participation;		
	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;	Information in PSPs reviewed contained limited information that would address this requirement. The Action Plans contained in the PSP document did not usually contain measurable goals, strategies, or supports. Most often they were simple statements such as "will participate in a walking routine" or "will stack towels".	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Through record review, interview, and observations there was little evidence of integrated planning. Most statements in a PSP were short and simple "Continue PNMP", or, "Continue current assistive equipment." There was no evidence of cross discipline discussion much less integration of service delivery. This provision of the SA will be reviewed in future monitoring visits as the expected revised state policy is implemented. to determine the adequacy of training in providing team members with the necessary skill sets to effectively collaborate in integrated planning and in developing and implementing comprehensive and effective plans for individuals.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Information contained in the PSPs reviewed provided at best minimal information that would contribute to integrated planning.	
	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	Information contained in the PSPs reviewed provided at best minimal information that would contribute to integrated planning.	

#	Provision	Assessment of Status	Compliance
	community settings; and		
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	The PSPs reviewed did not contain any information that would address this element of the SA.	
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.	From documentation review, interviews, and observations during this review it did not appear that coordination of goals, objectives, anticipated outcomes, services, supports, and treatments flowed from the PSP document and the PSP meeting. Individuals, for the most part, do appear to be receiving services however they do not appear to be coordinated.	
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.	From limited interviews it appears DSPs and other staff have access to PSPs. PSPs reviewed were comprehensible; however, for the most part they lacked sufficient detail to be of much use to staff charged with implementation.	
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	From the limited record review it did appear that for the most part these monthly reviews took place. The lack of qualitative substance in most PSPs described elsewhere in this document made this monthly review, for many individuals, perfunctory. For example, individuals with communication devices are not consistently followed by the Speech Pathologist resulting in no analysis of the data by the plan's author.	

#	Provision	Assessment of Status	Compliance
	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.		
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.	At this point the monitoring team does not believe additional training in the overall requirements for PSP planning should occur until the planned development of statewide policy and procedure intended to ensure compliance with this section of the SA is completed. There are some areas that merit immediate attention. Refer to provision O-5 for additional information relevant to Physical and Nutritional Management. The new policy will hopefully include specific training requirements consistent with the SA.	
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	The monitoring team did not review any new admissions during this visit.	

#	Provision	Assessment of Status	Compliance
	into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.		
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.	RGSC produced a document entitled "Personal Support Plan Meeting/Documentation Monitoring Checklist, dated 5/8/08. Through interview it was determined this document is not in use by the QA staff. Hopefully the statewide policy currently under development will include specific provisions addresses PSP QA.	

Recommendations:	**Recommenda**
1. Once State Policy is established RGSC will need to use it to create its own policy that can describe in detail, and in operational terms, the elements that will be necessary to lead to compliance with the elements of the SA. 2. RGSC needs to take steps to qualitatively improve its assessment processes and to begin a process where there is cross disciplinary discussion of assessment results and meaning. 3. RGSC needs to establish a mechanism where PNAs can develop a working understanding of the PSP process, the interdisciplinary nature of it, the benefits of integrated planning, and the relationship to all this to their daily work.	

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:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement, including but not limited to the items below. **Documents Reviewed:** 1. RGSC SOP 600 01 Person Directed Planning, dated July, 2003 2. RGSC SOP 600 02 Development and Monitoring of Individual Program Plans, Person Directed Approach, dated September, 1992 3. Person Directed Planning Process Slide Presentation 4. Personal Focus Worksheet 5. Person Directed Planning Training Assessment form 6. PSPs and attached assessments for Individual # 75 and #77 7. PSPs for Individuals #35, 55, 108, and 122 8. Additional PSPs, CLDPs, and other records reviewed by members of the monitoring team, as identified in Section F and sections below. 9. Personal Support Plan (PSP) Monitoring Checklist form **People Interviewed:** **Meeting Attended/Observations:** 1. PSP meetings for Individuals #77 and #108
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Disciplines generally work in a parallel manner in development of PSPs. The PST reviews recommendations and agrees or disagrees, but there is little substantive interdisciplinary discussion demonstrated in the planning meetings or documented in records. There are many examples in which lack of integration in clinical services may result in less than optimal supports and services.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology,	There was little evidence that a systematic process was in place to ensure assessment results were incorporated into the development and implementation of integrated program planning for the individual. The PSP document itself is organized so that each department provides recommendations upon which other participants comment and note simply whether the team agreed or not. The PSP meetings attended matched the document in that reports were presented, the team asked questions, and there was	

#	Provision	Assessment of Status	Compliance
	psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	minimal joint decision-making that involved discussion of information from more than one discipline at a time. The absence of regular substantive interdisciplinary discussion, and the quality of assessments and evaluations (e.g. nursing and physical management) referenced elsewhere in the report are significant barriers to compliance with this element of the SA. Examples of lack of integration in clinical services include the following: • There is no collaboration or cohesion between psychology and speech pathology as it relates to behavior support plans and the development of augmentative communication plans. For example: o Individual #51 often approaches people and grabs them in an effort to socialize;, however, there is no assessment or supports from a communication aspect to address this issue. • Currently, therapy (OT, PT, and SLP) has no role in developing oral hygiene plans or input into the method in which oral medication is provided. • The Facility's dental reports failed to provide documentation regarding PSP strategies established to ensure that pre-treatment sedation is administered only when less restrictive interventions have failed or been deemed inappropriate. Documentation of integrated planning to minimize use of pre-treatment sedation is lacking. • Although the HST members gave their own reports on the above individuals, when reviewing NCP and/or HMP plans there were often inconsistencies and conflicting information identified between nursing and other disciplines as was evidenced by the aspiration NCP for individual #51 that stated he received pureed foods while his Physical and Nutritional Management Plan (PNMP) stated he received chopped foods.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	This will be monitored at the first compliance review. Based on interviews, this varies across disciplines. However, there is no formal process or guidelines to determine when to refer for PST review of recommendations.	

Recommendations:

1. Development of integrated planning is a long and difficult process. The Facility should begin to identify opportunities for integrated planning and engage staff in identifying means to make the PSP/PST process an interdisciplinary planning process rather than a reporting process.
2. Establish policy and procedures for review and decisions regarding recommendations from non-Facility clinicians, including guidelines for referral of recommendations to the PST.

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:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement, including but not limited to the items below. **Documents Reviewed:** 1. Review of records for Individuals #47, #108, #51, #39, #8, and #101 2. Additional PSPs, CLDPs, and other records reviewed by members of the monitoring team, as identified in sections below. **People Interviewed:** Interviews with various discipline staff by the members of the monitoring team, as identified in sections below. **Meeting Attended/Observations:** 1. PSP meetings for Individuals #77 and #108 2. Meetings attended by members of the monitoring team, as identified in sections below.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Assessments are generally being done in accordance with policy timelines, but many assessments lack complete and detailed information that is needed for communication to other disciplines and for timely detection of individuals' needs.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	Assessments are generally being done per policy timelines. Many assessments lack complete and detailed information that would be needed for communication to other disciplines and for timely detection of individuals' needs. Review of Individuals #47, #108, #51, #39, #8, and #101showed Nursing Annual and Quarterly Assessments completed as scheduled according to their PSP calendar. Some sections of the assessments did not contain substantive information. Refer to Provision M.2. All individuals at RGSC have been provided with physical and occupational therapy assessments annually if receiving services and every 3 years if not receiving services; however, the assessments are lacking in detail as it relates to providing the justification of recommended interventions and how these interventions are meaningful to the individual and improve their overall level of functioning. Refer to Provision P.1. Per interview with the Habilitation Coordinator and document review, there was no clear	

#	Provision	Assessment of Status	Compliance
		policy or process that defines the schedule or criteria regarding whether an individual receives a speech update or full assessment. In addition, there was no policy in place that defines the frequency in which such assessments would be provided. Refer to Provision R.2.	
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.	At the time this report was issued, information on the Facility's compliance with this provision on medical and psychiatric diagnoses was not available.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The baseline review did not permit identification of enough examples to evaluate this adequately. However, there are a number of issues that are likely to lead to instances in which treatments and interventions are not timely, including the following: • Identification of risk is not consistent with clinical need and does not adequately trigger a risk-based frequency of assessments. As a result, intervention may not be timely if an individual's health or behavioral risk changes. • The use of inaccurate equipment for measures of physical condition (e.g., blood pressure) may lead to inappropriate treatment decisions. • Although Quarterly Drug Regimen Reviews and Annual DUE Reviews were conducted, the Drug Regimen Review Policy and Procedure failed to describe procedures for conducting, reviewing, and taking remedial action. • Plans developed by the PT/OT assessments include positioning, dining cards, and PNMPs. Vague terminology is present throughout these plans resulting in multiple interpretations of what is required for the individual.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and	The use of clinical indicators of efficacy of treatment needs continuing development. For example, data to identify effect of Positive Behavior Support Plans (PBSPs) are not tailored to the specific characteristics of the undesired behaviors targeted for reduction, may not be collected regularly, are usually not gathered for behaviors intended to replace the undesired behaviors, and there is little indication that intervention strategies	

#	Provision	Assessment of Status	Compliance
	interventions shall be determined in a clinically justified manner.	are revised in a timely manner in response to data. Effectiveness of Physical and Nutritional Management Plans (PNMPs) is not clearly monitored. Nursing annual and quarterly assessments failed to contain substantive information documented in their respective comment sections describing clinical outcomes, (e.g., whether the individuals' health status were progressing, maintaining, or regressing).	
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 few monitoring systems in place to assess nursing care and clinical outcomes at the time of the monitoring team's review. As a result of the limited assessment information contained in the records, as identified above, Nursing Care Plans (NCPs) and/or Health Maintenance Plans (HMPs) were not adequate to meet individuals' total health care needs. There needs to be a monitoring system in place to ensure that NCPs and/or HMPs meet individuals' total health care needs, interventions are appropriate, implemented, and their effectiveness evaluated. Individuals who have experienced aspiration pneumonia are identified as being at low risk for dysphagia, which may result in inadequate assessment and follow-up to ensure continuing health. The same finding is true for people who have had numerous falls.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The sections in Nursing Quarterly Assessments listing lab values and diagnostic tests, consults, and system reviews failed to contain substantive information documented in their respective comment sections describing clinical outcomes, (e.g., whether the individuals' health status were progressing, maintaining, or regressing, strategies that are working or not working, and to recommend changes, if indicated, in strategies, support and/or services). There is not a process in place that tracks PNM data so that it may be analyzed and used to drive future services. Data collection procedures for PNMPs are not tailored to the specific characteristics of the undesired behaviors targeted for reduction. Rather, a global strategy for data collection, involving frequency counts across lengthy intervals, is applied to the majority of undesired behaviors regardless of the parameters of those behaviors. Furthermore, records reflect that it is not uncommon for data to be unavailable or not reported for several days per month. Data regarding replacement behaviors is very seldom collected at all.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical	The Facility needs to continue to develop policies, procedures, and guidelines to correct the issues identified in this Section and in other provisions of the Settlement Agreement.	

#	Provision	Assessment of Status	Compliance
	services policies, procedures, and guidelines to implement the provisions of Section H.		

Recommendations:

1. The Facility needs to continue to develop policies, procedures, and guidelines to correct the issues identified in this Section and in other provisions of the Settlement Agreement. An example is the need to identify criteria regarding whether an individual receives a speech update or full assessment and a schedule or frequency of assessments.
2. In order to assist with decisions on priorities for support and services to individuals, the risk policy should be revised to identify risk accurately and establish how risk affects frequency and type of assessments, monitoring, and supports.
3. The Facility should continue to develop more useful indicators of clinical and intervention efficacy and health status.

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:** Because this is a baseline review a comprehensive set of documents was reviewed to ensure proper identification of subject matter specific information. Similarly, a number of staff, particularly administrative staff, were interviewed on SA provisions relevant to Section C, D, E, and I. The following activities occurred to assess compliance: **Documents Reviewed:** 1. DADS Policy #002.1 Protection from Harm – Abuse, Neglect, and Incident Management, dated 11/06/09. 2. DADS Policy #001: Use of Restraint, dated 8/31/09. 3. Health Care Guidelines, dated May 2009. 4. RGSC SOP MR 800-10 At Risk Individuals, dated March, 2009 5. RGSC SOP MR 700-14 – The Use of Restraint. 6. Restraint records for individuals #1, #36, #47, and #122 7. PMAB Training Curriculum – restraint section 8. Client Records for individuals #5, #35, #79, and # 85 9. All documents referenced in baseline document request including risk screening tools and related policy and procedures 10. Table of Contents of the RGSC Management Plan 11. Performance Improvement Council (PIC) report 12. Most current Trend Analysis Report 13. Sample Root Cause Analysis 14. Corrective Action Plans (CAP) for 6 most recent incidents 15. Daily Dorm Reports for 2/24/10 16. Incident Management Daily Review minutes for 10/5/09, 9/11/09,3/2/10 17. Comprehensive record reviews of four individuals (Individual #19, Individual #51, Individual #47, and Individual #101) 18. Partial record reviews of 12 individuals (Individual #94, Individual #10, Individual #96, Individual #60, Individual #15, Individual #140, Individual #79, Individual #113, Individual #55, Individual #85, Individual #36 and Individual #27. **People Interviewed:** 1. Sonia Hernandez-Keeble, Superintendent 2. Blas Ortiz, Assistant Superintendent 3. Mary Ramos, Quality Management Director 4. Bertha Lopez, MR Services Program Director 5. Rosie Sanchez, QE Coordinator 6. Alondra Machado, Data Analyst 7. Megan Gianotti, Assistant MR Program Director

	8. Dennis Provaznik, Incident Management Coordinator 9. Myrna Wolfe, QMRP Coordinator 10. Karina Serratos, Facility Investigator 11. Vina Guerrero, Training Director 12. Vicente Arismendi, Staff Trainer 13. Ray Ramos, Risk Manager 14. Eli Perez, DFPS Investigator 15. Direct care staff (6) **Meetings Attended/Observations:** 1. Human Rights Committee meeting 3/4/10 2. Personal Support Team meeting 3/4/10 3. Discharge Planning meeting 3/2/10 4. Incident Management Team meeting 3/2/10 5. Living area observations, including observations of individuals receiving 1:1 supervision. Specific observations of Individuals #4, #27, #51, #82, #113, and #116
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor Assessment: RGSC uses a number of tools that either are used specifically to identify risk or could be. These are primarily in the nursing and PNMP area. They do not appear to be used in a coordinated manner that allows clinicians to collaborate in an interdisciplinary manner to assess risk and jointly develop strategies to mitigate risk. Individuals who are at a "high risk" are not being identified and therefore may not be receiving the care and treatment required to prevent future illness. While most individuals have a PNMP, the PNMPs are not considered to be appropriate due to oral hygiene, medication administration, behavioral information, and signs and symptoms associated with aspiration or decline not being included as part of the document. Additionally, the assessment process involved in the development of the PNMPs is flawed secondary to little input being provided by therapy regarding positioning for GERD management, oral hygiene techniques, water safety and presentation of medications. If there is a change in care, all plans relevant to that individual are not always updated and trained in an efficient manner.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18	DADS completed the At Risk Individuals policy on 10/5/09. DADS also provided the SSLC's with a set of risk screening tools that cover health risks, challenging behaviors, injuries, and polypharmacy.	

#	Provision	Assessment of Status	Compliance
	months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	RGSC SOP MR 400-02 entitled At Risk Individuals. This policy was established in March 2009 and revised in January 2010. Thorough review of the "At Risk" policy revealed multiple issues. One was that the center was incorrectly following the policy as RGSC was placing the majority of their individuals as being at "low risk" when they should have been placed as at "medium risk." Second, the policy as written is flawed in its ability to identify those who are at a "high risk" of physical and nutritional decline. In its current state, the policy identifies individuals as being at "High Risk" if they are having an acute issue, "Medium Risk" if they require ongoing supports (i.e., a PNMP), and "Low Risk" if they do not require supports. Following the policy as written would result in RGSC having the majority of its population listed as "Medium Risk" since most of the individuals have PNMPs. This type of risk classification system is not functional or useful to the clinicians or the individuals living at RGSC. Examples that the current system is not accurately identifying those who are at risk include: • Individual #94 was identified as having severe pocketing and severe oral residue and required to be on a pureed diet but was listed as being at a "Low Risk" of aspiration/choking. • Individual #10 was identified as having moderate to severe pharyngeal dysphagia and had a hospital visit on 1/21/10 due to showing signs of aspiration but was listed as being at a "Low risk" of aspiration/choking. • Individual #51 was diagnosed with aspiration on 4/28/09 but was listed as being at a "Low risk" of aspiration/choking. Constipation is another preventable condition given appropriate care. As with other conditions, RGSC is failing to identify all those individuals truly at risk and this hampers or eliminates the possibility of providing proper preventative services and supports. For example: • Individual #96 and Individual #60 received medications for constipation but are listed as being at a "Low Risk" of constipation. As with Aspiration and Constipation; falls are not being adequately categorized as it relates to risk. For example: • Individual #15 had falls occurring on 11/30/09 and 1/18/10 but was listed as being at a "Low Risk" of injury. • Individual #140 had falls occurring on 11-17-0, 11-21-09, 11-23-09, 12-14-09,	

#	Provision	Assessment of Status	Compliance
		12-21-09, and 12-29-09. The Health Support Team reviewed the case and again was listed as being at a "Low Risk" of injury. In addition to the issue noted above, there was no criterion that guides the team in determining level of risk. The level of risk is highly subjective. Another issue was that there was no screening that focuses on pneumonia risk. Aspiration/Choking is screened and this screening does contain some components of pneumonia risk identification but the issues leading to an increased risk of pneumonia and choking often varies, thus making a single "catch all" screening very difficult to be highly accurate.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	As described in Section I1 RGSC does not have an effective system to meet this requirement of the SA.	
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	As described in Section I1 RGSC does not have an effective system to meet this requirement of the SA.	

#	Provision	Assessment of Status	Compliance
	ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.		

Recommendations:

1. There is a variety of information available from which to identify individuals who are potentially at risk. The policies and procedures for a risk management system should draw together the various assessment instruments, other relevant information, and procedures into one process that can reliably identify individuals whose health or well-being place them at risk and need special planning to mitigate risk. A process to bring this all together should include a review of each assessment tool to ensure they measure what is intended to be measured and criteria to assign risk levels is as objective as possible.
2. Individuals who are at a high risk are not being identified due to the criteria set forth by the "At Risk" policy as well as inadequate follow through of said policy. Therefore, RGSC in coordination with other state centers and the state of Texas should revisit the policy and redesign so that is identifies those who are at risk. Additionally, the level of risk should be openly shared with staff and used to help drive and shape future services

Recommenda

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:** At the time this report was issued, information on the Facility's provision of psychiatric treatment was not available. **Documents Reviewed:** **People Interviewed:** **Meeting Attended/Observations:**
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment:

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.		
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.		
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately,		

#	Provision	Assessment of Status	Compliance
	psychotropic medications shall not be used as punishment.		
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.		
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.		
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.		

#	Provision	Assessment of Status	Compliance
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.		
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.		
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,		

#	Provision	Assessment of Status	Compliance
	shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.		
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.		
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		

#	Provision	Assessment of Status	Compliance
	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.		
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.		
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		

#	Provision	Assessment of Status	Compliance
	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.		
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.		
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.		

Recommendations:

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:** Documents that were reviewed included the annual PSP, PSP updates, SPOs, PBSPs, 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, and behavioral and functional assessments. These documents were reviewed for the following individuals: 1, 11, 27, 36, 48, 51, 61, 63, 75, 79, 80, 82, 94, 96, 101, 133, 140, and 149. **People Interviewed:** 1. Eric Lopez, Rehabilitation Therapy Technician 2. Arnold Gonzalez, Rehabilitation Therapy Technician 3. James Almendarez, Vocational Service Coordinator 4. Vickie Martinez, PNA at El Paisano 5. Myrna Wolf, QMRP Coordinator 6. Megan Gianotti, Assistant MR Program Director 7. Cheryl Fielding, PhD, BCBA, Contract Psychologist 8. Alysa King, MS, LPC-I, Contract Psychologist 9. Estefana Mendoza, MS, Contract Psychologist 10. Michelle Melchor, BS, Psychology Assistant 11. David Moron, MD, Clinical Director 12. Babu Draksharam, MD, Contract Psychiatrist **Meeting Attended/Observations:** 1. Observed at Vocational Services, rooms 7, 8, 15, shredding, pre-academic area 2. Observed numerous activities at El Paisano and La Paloma
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor Assessment: RGSC is currently faced with a variety of limitations in meeting the behavioral and mental health needs of the individuals living there. At the core of many of these issues is the minimal number of psychology personnel employed by the facility. Without sufficient numbers of well-qualified staff, RGSC will not be able to address many of the additional challenges. Related to the number of personnel is the ability of psychology staff to conduct adequate behavioral assessments and interventions. Many of the psychology personnel lack basic knowledge of applied behavior analysis or the evidence-based approaches to behavioral intervention. As a result, assessments of behavior are inadequate and fail to capture the relevant components of the behaviors in questions. This in

	turn results in behavioral interventions that lack validity and cannot be supported as being beneficial. Competence in applying behavioral principles is also lacking in staff members outside of the Psychology Department. Observations and interviews reflect that the majority of facility personnel lack the skills to apply formal or informal behavior change strategies. As a result, numerous undesired behaviors continue without intervention or are inadvertently strengthened by inappropriate interventions. Efforts to identify limitations in staff knowledge and offer supplemental training are notably lacking. Substantial limitations are also apparent in efforts by RGSC to document and monitor behavioral interventions. Data collection procedures lack individualization and sophistication. In addition, data may not be collected or interpreted for several weeks. When data are available, interdisciplinary teams often fail to modify treatment plans according to data trends. As a result of these and other noted limitations, it is evident that people living RGSC are unlikely to receive adequate intervention for undesired and problematic behaviors. Under some circumstances, these behaviors present a risk to the well-being and safety of the individual or other people around them.

#	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	At the time of the site visit, RGSC did not employ any full- or part-time psychology staff possessing Board Certification as a behavior analyst. Three weeks prior to the site visit, RGSC did enter into a contractual agreement with Dr. Cheryl Fielding, a Board Certified Behavior Analyst. Dr. Fielding's contractual agreement specifies that she will be responsible for providing 1) prioritization of individuals requiring intervention based upon the level of aggression and self-injury displayed as well as the overall frequency of undesired behavior, 2) Evaluating the quality of functional assessments, 3) Evaluating the quality of behavior support plans, 4) Evaluating the implementation fidelity of the behavior support plans 5) Providing staff development training modules regarding behavior assessment, intervention and data collection, and 6) Providing supervision for RGSC staff who are candidates for Board Certification as a behavior analyst. The participation of Dr. Fielding is a positive step taken by the facility in addressing the need for Board Certified Behavior Analysts. As with any contractual employee, there are weaknesses in such an arrangement. The greatest weakness is that Dr. Fielding will be available on-site for only 3 – 4 hours per week. That is a very limited amount of time considering the nature and extent of the services she has agreed to provide to the facility. Both Dr. Fielding and RGSC personnel discussed the possibility of Dr. Fielding providing students enrolled in a behavior analyst certification training program as student interns. At the time of the site visit, however, formal arrangements regarding the availability and services to be provided by the student interns had not been finalized. Therefore, while the involvement of Dr. Fielding and student interns could prove to be very beneficial to RGSC in meeting the obligations of the settlement agreement, a review of the arrangement during the next site visit will be required in order to determine the exact benefits for the facility.	

#	Provision	Assessment of Status	Compliance
	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.	Apart from the participation of Dr. Fielding, the development of behavior support plans was, at best, haphazard. In various interviews, it was reported that "no one" was officially responsible for conducting behavior assessments or developing behavior support plans. A contractual employee with a Masters degree in psychology stated that she had participated in the development of several behavior support plans. This individual is personable and enthusiastic but did not display the basic skills or knowledge essential to the development of empirically based and effective behavior interventions. This was also the case with other full-time and contractual employees of the Psychology Department. Megan Gianotti was the most knowledgeable of all psychologists interviewed at RGSC. Rather than serving in the Psychology Department, however, Dr. Gianotti is employed as the Assistant MR Program Director. Because of these circumstances, RGSC lacks the personnel qualified to develop behavior support plans and effectively address the undesired and potentially dangerous behavior of the individuals living at the facility.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	At the time of the site visit, RGSC did not employ a director of psychology, although the facility was recruiting to fill the vacant position. Megan Gianotti, the Assistant MR Program Director, was fulfilling a limited number of the duties typically performed by a psychology director, but was not identified as the Acting Director of the Psychology Department.	
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall	RGSC does not employ psychologists qualified to conduct adequate peer review. The Behavior Management Committee meets monthly or more often as needed to review behavior support plans, but this perfunctory review focuses upon a subjective determination of the need for, safety of and benefit from behavior support plans. No mechanism for external peer review exists.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>establish a peer-based system to review the quality of PBSPs.</td><td></td><td></td></tr>
<tr><td>K4</td><td>Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments</td><td>The records for 18 individuals were reviewed. This included review of PBSPs and data progress notes. The percentage of those records that reflected a standard methodology for data collection in specified areas is presented below.

<table><tr><td>Targeted behavior data collection sufficient to assess progress.</td><td>0.0%</td></tr><tr><td>Replacement behavior data collection sufficient to assess progress.</td><td>0.0%</td></tr><tr><td>Data reliability is assessed.</td><td>0.0%</td></tr><tr><td>Target behaviors analyzed individually.</td><td>0.0%</td></tr><tr><td>Targeted behaviors graphed sufficient for decision-making.</td><td>0.0%</td></tr><tr><td>Replacement behaviors graphed sufficient for decision-making.</td><td>0.0%</td></tr></table>
As these data reflect, the ability of RGSC to support the effectiveness of behavioral interventions is substantially compromised. Data collection procedures are not tailored to the specific characteristics of the undesired behaviors targeted for reduction. Rather, a global strategy for data collection, involving frequency counts across lengthy intervals, is applied to the majority of undesired behaviors regardless of the parameters of those behaviors. Furthermore, records reflect that it is not uncommon for data to be unavailable or not reported for several days per month. Data regarding replacement behaviors is very seldom collected at all.

The analysis of treatment data at RGSC lacks the sophistication necessary to determine treatment benefits even if data were of satisfactory integrity. Even when behavior support plans are indicated to be focused upon a specific target, assessment of treatment efficacy often reflects a more general "is the person better" approach of analysis than an attempt to determine of any treatment expectations have been met. For example, individual #80 has a PBSP that targets self-injury and compulsive behavior. Data reported in the progress notes include a variety of behaviors, such as aggression and poor cooperation, as benchmarks of progress or the lack thereof.

Graphs of data related to undesired behaviors are encountered in the records, but it is much more typical for treatment data to be reported in narrative or tabular format. No graphs of replacement behavior data were reported or encountered in the records. Furthermore, the graphs found in the records typically lack the required elements necessary to allow for determination of treatment efficacy. To improve the ability to make decisions based on data, RGSC should establish an expectation that graphs of undesired behaviors targeted for change in PBSPs and the behaviors planned to replace them will be included in the records. Training on development, use, and interpretation of graphs should be provided as needed.</td><td></td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.</td><td>The records for a total of 18 individuals were reviewed. The percentage of those records that reflected a standard methodology for monitoring and review of PBSPs is presented below.

<table><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>0.0%</td></tr><tr><td>Review is conducted by a BCBA.</td><td>0.0%</td></tr><tr><td>Input from direct care staff is solicited and documented.</td><td>0.0%</td></tr><tr><td>Modifications to the PBSP reflect data-based decisions.</td><td>0.0%</td></tr><tr><td>Criteria for revision are included in the PBSP.</td><td>0.0%</td></tr><tr><td>Progress evident, or program modified in timely manner (3 Months).</td><td>0.0%</td></tr></table>
Based upon records as well as discussion with Psychology Department staff, several weeks may pass between attempts to compile and interpret treatment data. Monthly progress notes reflect that at times months may pass between attempts to compile behavior data.

The general lack of meaningful behavior data makes interpretation of revisions to treatment difficult. Even if the reported data are accepted at face value, there is little indication that intervention strategies are revised in a timely manner in response to data. Modifications to behavioral interventions are generally based upon scheduled time frames, such as annual reviews. Timely revisions in behavioral interventions are further compromised by a lack of specific and detailed treatment expectations in most intervention plans. For example, data for Individual #36 revealed no displays of a target behavior for 8 months with no revision of the PBSP. In several other records, individuals continued to display target behaviors at rates similar to pre-treatment levels throughout the PSP year, at which time the same PBSP was continued. When modifications are made, they may follow incidents and short-term trends in difficult behavior rather than predetermined treatment expectations.</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</td><td>The records for a total of 18 individuals were reviewed. The percentage of those records that reflected a standard psychological assessment procedure is presented below.

<table><tr><td>Standardized assessment or review of intellectual and cognitive ability.</td><td>0.0%</td></tr><tr><td>Standardized assessment of adaptive ability.</td><td>0.0%</td></tr><tr><td>Screening for psychopathology, emotional and behavioral issues.</td><td>0.0%</td></tr><tr><td>Assessment or review of biological, physical and medical status.</td><td>0.0%</td></tr><tr><td>Review of personal history.</td><td>11.1%</td></tr></table>
RGSC has initiated a new format and schedule for psychological assessments. Staff members anticipate this</td><td></td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>
new format and schedule will address the shortcomings evident in the current psychological assessment process. Further reviews will be needed to determine if the anticipated benefits come to pass.

At present, the records for the majority of individuals residing at RGSC are inadequate to the task of identifying the adaptive, emotional, psychological and behavioral characteristics of an individual. Intellectual and cognitive assessments are often from several years to a decade or more in the past. Formal procedures to assess adaptive, emotional, psychological and behavioral factors are seldom evident, resulting in reports that reflect subjective, general information.

The records for a total of 18 individuals were reviewed. The percentage of those records that reflected a standard functional assessment procedure is presented below.

<table>
<tr><td>A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis.</td><td>0.0%</td></tr>
<tr><td>Differentiation between learned and biologically based behaviors.</td><td>0.0%</td></tr>
<tr><td>Identification of setting events and motivating operations relevant to the undesired behavior.</td><td>0.0%</td></tr>
<tr><td>Identification of antecedents relevant to the undesired behavior.</td><td>0.0%</td></tr>
<tr><td>Identification of consequences relevant to the undesired behavior.</td><td>0.0%</td></tr>
<tr><td>Identification of functions relevant to the undesired behavior.</td><td>0.0%</td></tr>
<tr><td>Identification of functionally equivalent replacement behaviors relevant to the undesired behavior.</td><td>0.0%</td></tr>
<tr><td>Identification of preferences and reinforcers.</td><td>0.0%</td></tr>
</table>

Although documents with the label of functional assessment are present in many records, the content of those documents reflect that functional assessments meeting current minimum expectations are not conducted at RGSC. Interviews with several members of the Psychology Department revealed a general lack of familiarity with the theory behind or application of functional assessment procedures. Staff members were unable to describe the conditions under which a functional assessment should be initiated or revised, and could not provide a general description of what a functional assessment process should consist of.

A review of the available documents labeled as functional assessments revealed narrative statements that lacked an empirical approach to behavioral assessment. These documents typically consisted of broad, general statements about behavior that appeared to be derived from anecdotal reports or observations conducted under conditions lacking any experimental control. As one example, the following redacted statement was provided as the functional assessment findings regarding self-injury displayed by Individual #31.

Self-injury can be exhibited when prompted repeatedly. Self-injury is also exhibited when Individual #31 appears anxious (rocking back and forth fast and making groaning noises.). Loud, crowded
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		environments (closer than arm's length) appear to make Individual #31 anxious. Self-injury is maintained by positive and negative reinforcement. Although these statements could be valid regarding self-injury, there is no indication that adequate assessments were conducted upon which such conclusions could be based. As psychology personnel were generally unable to describe components of, or procedures involved in completing, a functional assessment, it is unlikely that an adequate assessment was conducted and then not fully reported. As a result of the lack of sophistication in functional assessment, any statements regarding behavioral contingencies or functions could not be supported and were inadequate to the task of developing behavioral interventions. The functional assessment is reviewed when the Individual does not meet treatment expectations and is revised as needed with a maximum of one year between reviews. 0.0% As indicated elsewhere in this section of the report, detailed and specific treatment expectations are not routinely included in behavioral interventions. Therefore, it cannot be easily determined exactly when a functional assessment should be revised. A review of the available records and treatment data reflects, however, that functional assessments are revised only as part of the annual PSP process. Identification of behavioral indices of psychopathology 0.0% Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities 0.0% In a review of the records for 18 individuals living at RGSC, there was no indication that any individual had been assessed for psychopathology by means of a formal assessment instrument designed for use with individuals diagnosed with an intellectual or developmental disability. Psychology staff members and psychiatrists at RGSC lacked familiarity with such instruments. Furthermore, a systematic, coherent approach to formulating intervention strategies to address mental health and behavioral disturbances was not apparent. Based upon interviews and observations, the integration of behavioral and psychiatric assessment and intervention at RGSC is at best informal. Psychiatrists were often unable to recall the names of the individuals that they served or the specific reasons for treatment decisions. In written documentation of psychiatric treatment decisions, the psychiatrists often reported the wrong diagnosis, as based upon their own earlier assessments, and frequently changed diagnoses from one quarter to the next without objective supporting evidence. Despite such circumstances, the changes in diagnosis did not result in changes in the psychotropic drug regimens or behavioral interventions.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Regardless of the diagnosis offered, the documented behavioral correlates for mental illnesses typically consisted of aggression or other behaviors that are dangerous to the person or those around them. Aggressive and other dangerous behaviors can be correlates of the symptoms of mental illness. The determination of this correlation must be based, however, upon careful and rigorous assessment including functional assessment of behavior and objective assessment of psychopathology that identifies such a relationship as clearly as possible. Without such assessments, the need for psychotropic medication cannot be unequivocally supported. As these assessments of behavior and psychopathology at RGSC are inadequate, the use of and need for many psychotropic drugs cannot be supported.</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>As stated elsewhere in this section of the report, it does not appear that psychological assessments are based upon objective, empirical evidence. The data below reflect a review of the records for 18 individuals living at RGSC regarding psychological assessments.

<table><tr><td>Individual’s records demonstrate that the assessment is based on</td><td>0.0%</td></tr><tr><td>• Current,</td><td>0.0%</td></tr><tr><td>• Accurate, and</td><td>0.0%</td></tr><tr><td>• Complete clinical and behavioral data.</td><td>0.0%</td></tr></table></td><td></td></tr>
<tr><td>K7</td><td>Within eighteen months of the Effective Date hereof or one month from the individual’s admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of</td><td>The data below reflect a review of the records of 18 individuals regarding the frequency of psychological assessments. RGSC completes a psychological assessment on every individual on at least an annual basis, as well as within 30 days of admission. As indicated elsewhere in this report, however, the assessment process as defined by RGSC does not comport with currently accepted practices in the field of applied behavior analysis or intellectual disabilities.

<table><tr><td>Individual records demonstrate that these psychological assessments are conducted as often as needed, and at least annually, for each individual.</td><td>0.0%</td></tr><tr><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>88.9%</td></tr></table></td><td></td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.</td><td></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>RGSC does not currently provide non-positive-behavior-support-plan interventions for the individuals living at the facility.</td><td></td></tr>
<tr><td>K9</td><td>By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting</td><td>The data below reflect a review of the records of 18 individuals regarding consents for restrictive procedures included in behavioral and psychopharmacological interventions. In the cases reviewed, slightly over three quarters of the individuals who required consent had acceptable consents in their charts. The remaining individuals typically had the required consents, but consent had not been obtained within the stipulated time frame.

<table><tr><td>Necessary consents and approvals are obtained for each PBSP and safety plan prior to implementation.</td><td>77.8%</td></tr><tr><td>Within 14 days of obtaining consents the PBSP or safety plan will be implemented.</td><td>77.8%</td></tr></table>
Although consents were in place for the majority of individuals for whom consent was required, there is concern about the validity of the consent documents. Effective interventions for behavior disturbance and mental illness require rigorous and comprehensive assessments. As noted elsewhere in this section,</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	assessments of behavior and psychopathology at RGSC do not meet minimum expectations according to current best practice. Furthermore, the interventions that are based upon the completed assessments are unlikely to be empirically sound and the data collected regarding those interventions are of unknown reliability. Therefore, the restrictive procedures for which consent was obtained cannot be supported as necessary, beneficial or reflective of the least restrictive available strategies. This creates a situation where the information provided to the signatory of the consent may incorrectly represent the need for or justification of the use of restrictive procedures. The data below reflect a review of the records of 18 individuals regarding the elements included in behavioral interventions. In the majority of cases, the reviewed behavioral interventions fell far short of current best practices under applied behavior analysis.	

The PBSP for which consent was obtained conforms to current best practices in applied behavior analysis. (All items below must be FS for this to be scored FS)		0.0%
a.	Rationale for selection of the proposed intervention.	0.0%
b.	History of prior intervention strategies and outcomes.	0.0%
c.	Consideration of medical, psychiatric and healthcare issues.	0.0%
d.	Operational definitions of target behaviors.	0.0%
e.	Operational definitions of replacement behaviors.	0.0%
f.	Description of potential function(s) of behavior.	0.0%
g.	Use of positive reinforcement sufficient for the strengthening of desired behavior.	0.0%
h.	Strategies addressing setting event and motivating operation issues.	0.0%
i.	Strategies addressing antecedent issues.	0.0%
j.	Strategies that include the teaching of desired replacement behaviors.	0.0%
k.	Strategies to weaken undesired behavior.	0.0%
l.	Description of data collection procedures.	0.0%
m.	Baseline or comparison data.	0.0%
n.	Treatment expectations and timeframes written in objective, observable, and measureable terms.	0.0%
o.	Clear, simple, precise interventions for responding to the behavior when it occurs.	11.1%
p.	Signature of individual responsible for developing the PBSP.	11.1%
Evidence that the intervention is based on functional assessment results, individual preferences, and on-going individual behavior.		0.0%

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Noted weaknesses included the following areas.
The rationale for intervention plans was typically vague or based upon anecdotal information rather than careful functional assessment.
The review of the individual's history, in terms of both personal events and previously attempted interventions, lacked sufficient detail and specificity to be useful.
Definitions for treatment targets and replacement behaviors were often very broad, all encompassing statements. As a result, most staff would be unable to identify the treatment target or replacement behavior. Such circumstances result in behavioral interventions being implemented incorrectly, for the wrong behavior or in ways that actually increase the behaviors targeted for reduction.
Instructions for data collection, when included, often lacked the specificity needed to ensure that staff recorded occurrences of behavior in the manner intended.
Statements regarding treatment expectations often appeared arbitrary or tied to schedules for annual reviews rather than reasonable expectations of treatment efficacy. This has the potential to result in failure to revise intervention plans as needed.
Behavioral intervention methodology sections of the intervention plans were often written in a style that included unnecessary jargon, overly complex language or comments that were not useful in the implementation of the plan. The results were Positive Behavior Intervention Plans that, even if meeting best practices, were unlikely to be implemented effectively or consistently.</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</td><td>The data below reflect a review of the records of 18 individuals regarding expectations for data collection and presentation. At the time of the site visit, psychology staff at RGSC did not conduct any reliability measures of behavior data. In addition, all behavior data was presented in narrative or tabular form rather than in appropriately developed graphs.

<table>
<tr><td colspan="2">Inter-observer agreement exists for PBSP data (All items below must be FS for this to be scored FS).</td><td>0.0%</td></tr>
<tr><td>a.</td><td>IOA for target behavior data.</td><td>0.0%</td></tr>
<tr><td>b.</td><td>IOA for replacement behavior data.</td><td>0.0%</td></tr>
<tr><td>c.</td><td>IOA meets minimum expectations.</td><td>0.0%</td></tr>
<tr><td colspan="2">PBSP data are graphed at least monthly</td><td>0.0%</td></tr>
<tr><td colspan="2">Data graphs are adequate for interpretation (All items below must be FS for this to be scored FS).</td><td>0.0%</td></tr>
<tr><td>a.</td><td>The graph is appropriate to the nature of the data.</td><td>0.0%</td></tr>
<tr><td>b.</td><td>Horizontal axis and label.</td><td>0.0%</td></tr>
<tr><td>c.</td><td>Vertical axis and label.</td><td>0.0%</td></tr>
<tr><td>d.</td><td>Condition change lines.</td><td>0.0%</td></tr>
<tr><td>e.</td><td>Condition labels.</td><td>0.0%</td></tr>
</table></td><td></td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.</td><td><table>
<tr><td>f.</td><td>Data points and path.</td><td>0.0%</td></tr>
<tr><td>g.</td><td>IOA and data integrity.</td><td>0.0%</td></tr>
<tr><td>h.</td><td>Demarcation of changes in medication, health status or other relevant events.</td><td>0.0%</td></tr>
</table></td><td></td></tr>
<tr><td>K11</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.</td><td>The data below reflect a review of the records of 18 individuals regarding treatment integrity for behavioral interventions. Based upon the records reviewed, as well as staff interviews and observations of residential, educational and vocational settings, RGSC staff members are typically unable or unwilling to implement intervention plans. During observations of numerous settings, staff members often did not intervene when individuals displayed undesired behaviors ranging from stereotypic body movements to threats of imminent harm to self or others. Dining rooms were most notable for the lack of intervention plan implementation. During meals, numerous individuals were observed to rock, wander about, curse, steal food and threaten or attempt aggression with only minimal staff intervention. When questioned about behavioral interventions for these individuals, staff members often were unable to describe the appropriate intervention methodology or offered statements such as, “That doesn’t work,” “(The behavior) wasn’t that bad,” or “That’s just how s/he is.”

RGSC did not at the time of the site visit have a system for assessing treatment integrity.

<table>
<tr><td>Staff are able to explain how they implement the individual’s PBSP.</td><td>0.0%</td></tr>
<tr><td>The facility implements a system to monitor and ensure treatment integrity.</td><td>0.0%</td></tr>
<tr><td>Observations of staff and individuals demonstrate at least 80% treatment integrity.</td><td>0.0%</td></tr>
<tr><td>Written style and length of plan allows for staff understanding.</td><td>0.0%</td></tr>
</table></td><td></td></tr>
<tr><td>K12</td><td>Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all</td><td>The data below reflect a review of the records of 18 individuals regarding training staff members on the implementation of behavioral interventions.

<table>
<tr><td>Training logs reflect that all staff have received training on individual PBSPs’:</td><td>0.0%</td></tr>
<tr><td>Overall purpose</td><td>0.0%</td></tr>
<tr><td>Specific objectives</td><td>0.0%</td></tr>
<tr><td>Staff training includes a combination of didactic, modeled and in vivo strategies.</td><td>0.0%</td></tr>
</table></td><td></td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>
<table>
<tr><td>Staff training is conducted prior to PBSP implementation.</td><td>0.0%</td></tr>
<tr><td>Staff training is conducted throughout the duration of the PBSP.</td><td>0.0%</td></tr>
<tr><td>The facility has implemented a system to ensure that pulled and relief staff, receive competency based training on PBSPs they will be responsible to implement.</td><td>0.0%</td></tr>
<tr><td>Staff training is provided in part by the professional responsible for the development of the PBSP.</td><td>0.0%</td></tr>
</table>

RGSC staff members consistently reported that training on behavioral interventions involved being read portions of the intervention plan followed by a test. In several situations, staff indicated that the reading of the intervention plan covered “Only the high points,” and that staff were expected to read the intervention plan later. This training modality occurred en masse during the site visit in order to address a recent regulatory review. The responsibility for training behavioral interventions can but is not required to involve the psychology staff member who developed the intervention.

Again, according to staff members, training on behavioral interventions occurs only when the intervention is first implemented. Only under exceptional circumstances, such as those resulting from the regulatory review, are additional trainings offered after the intervention is implemented.

RGSC does make available reference materials regarding behavioral interventions for staff that are pulled from other locations as relief. Staff members were rarely observed to access these materials, and many reported that time did not allow for extensive review.</td><td></td></tr>
<tr><td>K13</td><td>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</td><td>Although plans were presented for increasing the availability of psychology staff members who possess Board Certification in Behavior Analysis, at the time of the site visit the only board certified behavior analyst at RGSC was a consultant who provides 2 – 3 hours of service per week.

<table>
<tr><td>Program maintains an average of 1 BCBA to every 30 individuals.</td><td>0.0%</td></tr>
<tr><td>Program maintains one psychology assistant for every 2 BCBAs.</td><td>0.0%</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	professionals.		

Recommendations:

1. RGSC should aggressively recruit psychologists with substantial experience in applied behavior analysis with people who are diagnosed with intellectual and developmental disorders. It is highly recommended that persons be hired who have board certification as a behavior analyst. In the absence of such potential employees, experience combined with a willingness to obtain board certification within 12 to 24 months is recommended.
2. RGSC should continue and, if possible, expand the participation of Dr. Fielding or other consultants with Board Certification as a behavior analyst until full-time employees can be hired and trained.
3. RGSC should aggressively attempt to fill the Chief Psychologist position that was vacant at the time of the site visit. As with the filling of other psychology positions, it is advisable that the person hired as Chief Psychologist possesses Board Certification as a Behavior Analyst or have the ability to obtain Board Certification in 12 to 24 months.
4. RGSC should establish internal and external peer review committees. It is necessary that these committees focus upon the clinical and empirical qualities of behavioral services and function within the framework of current, generally accepted standards in terms of peer review.
5. RGSC currently lacks valid and reliable data regarding behavioral and psychiatric interventions. In order to improve the quality of data and ensure that interventions are beneficial and justified, it is recommended that RGSC develop data collection policies and procedures that reflect the national current, generally accepted standards and comport with an empirical, evidence-based approach to treatment. These policies and procedures should ensure that data collection is comprehensive, tailored to the characteristics of the behavior, valid, and reliable.
6. In addition to policies and procedures, staff must have the skills necessary to apply the policies and procedures. This includes not only psychology personnel, but also all staff who may be required to document, compile, interpret or otherwise use treatment data. In order to achieve this, RGSC will need to develop and implement a training curriculum on data collection. This training will need to be competency-based and conducted at regular intervals to ensure that data skills do not deteriorate over time.
7. Efforts to enhance data collection and data quality must also involve an on-going system for quality control. At a minimum, such quality control will need to include reliability measures, program integrity probes and review of treatment decisions. The review of treatment decisions should be structured so that the focus is upon the ability of the available data to support the treatment decisions and whether decision were made in a timely, objective and beneficial manner.
8. To improve the ability to make decisions based on data, RGSC should establish an expectation that graphs of undesired behaviors targeted for change in PBSPs and the behaviors planned to replace them will be included in the records. Training on development, use, and interpretation of graphs should be provided as needed.
9. At the time of the site visit, RGSC had recently implemented a revised format for psychological evaluations. This is a positive step. In order to ensure that the potential benefit of the revised format is achieved, the facility should develop and implement a training curriculum for psychologists that will provide the skills and knowledge necessary to make effective use of the format. In addition, a quality control process for psychological evaluations should be implemented.
10. The psychology staff members at RGSC currently lack basic skills in the use of functional assessment technology. For behavioral and psychiatric interventions to possess any validity and justification, it will be necessary for these skills to be greatly enhanced. It is recommended that RGSC develop and implement a training curriculum regarding functional assessment procedures, as well as the role and application of functional assessment in the development of behavioral and psychiatric interventions.
11. Substantial deficits were also noted at RGSC in the ability to determine and justify diagnoses of mental illness. Psychologists and psychiatrists need to increase the use of standardized and objective procedures when formulating diagnoses. Where such procedures are lacking, psychologists and psychiatrists should be prepared to use an empirical process to identify, monitor and modulate behavioral and pharmacological interventions for mental illness. To achieve this, it is recommended that training for psychologists and psychiatrists be obtained and that quality control procedures

are developed and implemented.

12. It is recommended that quality control procedures for informed consent be enhanced to ensure that consents meet all facility and regulatory requirements.
13. The quality and integrity of behavior intervention plans need to be greatly increased. Psychology personnel currently lack the ability to develop effective intervention plans that reflect current, generally accepted standards in applied behavior analysis. It is recommended that psychology staff be provided ample training in operant conditioning, learning theory, applied behavior analysis and the scientific method. This training should be competency-based with on-going assessment of knowledge and the application of skills. Furthermore, RGSC should develop minimum standards for the quality and content of all behavioral interventions, and implement a process for ensuring that all intervention plans meet the established standards. It is also recommended that these standards address the ability of PNA employees and other staff to understand and implement the interventions.
14. The methods currently used at RGSC to teach staff how to implement behavioral interventions is inadequate and results in poor treatment integrity. The facility should develop new training standards that reflect a competency-based approach to training. These standards should include initial training efforts, as well as on-going probes to assess staff ability to implement the interventions.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: At the time this report was issued, information on the Facility's provision of medical treatment was not available. **Documents Reviewed:** **People Interviewed:** **Meeting Attended/Observations:**
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment:

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.		
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.		

#	Provision	Assessment of Status	Compliance
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.		
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.		

Recommendations:

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:** **Documents:** 1. Texas Settlement Agreement (SA) and Health Care Guidelines (HCG) 2. RGSC Facility Map 3. RGSC Organizational Chart 4. RGSC Approved Symbols and Abbreviations 5. RGSC List of Nurses' Caseloads 6. RGSC Nursing Event Daily Log (used for shift reporting), blank form – obtained onsite 7. RGSC FY-2010 Active Position Status Report for the period Ending 1/15/2010 8. RGSC FY 2010 – MR – Contract PO 9. RGSC Meeting Schedules and March Meeting Schedules 10. RGSC MR Chart Index 11. Rio Grande State Center/South Texas Health Care System (STHCS) Nursing Manual: a. SOP NR100-03, Nursing Competency Policy, Date Established: October, 1998, Reviewed/Revised, February 2010 b. SOP NR200-90, Nursing Assessment/Evaluation, Date Established: December, 1998, Revised/Reviewed: March, 2010 c. SOP NR200-91, Quarterly Reviews, Date Established: December, 1998, Revised/Reviewed: March, 2010 d. SOP NR200-93, Nursing Assessment/Evaluation in Acute Situations, Date Established, December, 1998, Revised/Reviewed: March 2010 e. SOP NR200-94, Instructions for Post-Hospital Nursing Needs (Return to Living Area) Assessment, Date Established: June, 2003, Revised/Reviewed: December, 2008 f. SOP NR200-95, Physical Status Assessment, Date Established: September, 1998, Revised/Reviewed: March 2010 g. SOP NR200-96, Physical Therapy Evaluation, Date Established: December, 1998, Revised/Reviewed: March 2010 h. SOP NR200-97, Menstrual Record, Date Established: September, 1992, Revised/Reviewed: March 2010 i. SOP NR200-98, Referral to Nurse, Date established: September 1992, Revised/Reviewed: March 2010 j. SOP NR200-99, Supportive/Protection/Adaptive Devices, Date Established: December, 1998, Revised/Reviewed: March 2010 k. SOP NR200-99, Self-Administration of Medication, Date Established: June, 2003, Revised/Reviewed: March 2010 l. SOP NR200-100, Supportive/Protection/Adaptive Devices, Date Established: December, 1998, Revised/Reviewed: March 2010 m. SOP NR200-101, Pulse Oximeter, Date Established: October, 2003, Revised/Reviewed: March 2010

	n. SOP NR200-102, CPAP Care, Date Established: December, 2003, Revised/Reviewed: March 2010 o. SOP NR200-103, MOSES – Monitoring of Side Effects, Date Established: November, 2009 p. SOP NR200-104, DISCUS – Monitoring of Medication Side Effects and Tardive Dyskinesia,, Date Established: November, 2009 q. SOP NR200-105, Weight Management, Date Established: August, 2009, Next Review/Revision Date: March 2010 r. SOP NR200-106, Communication with Hospitals and Other Acute Care Facilities, Date Established: August, 2009 s. SOP NR200-107, Nutritional Management Team, Date Established: August 2009 t. SOP NR200-108, Guidelines for Use of Topical Skin Adhesive for Wound Closure, Date Established: May, 2004, Revised/Reviewed: March 2010 u. SOP NR200-109, Urinary Intermittent Catheterization, Date Established: June, 2004, Revised/Reviewed: March 2010 v. SOP NR200-110, Medical Care Plan, Date Established: August, 2004, Revised/Reviewed: March 2010 w. SOP NR200-111, Nursing Services, Date Established: August, 2009, Next Review/Revision Date: March 2010 x. SOP NR200-112, Care plan Development, Date Established: August, 2009, Reviewed/Revised: November, 2009, Next Review/revision Date: March 2010 y. SOP NR200-113, At Risk Individuals, Date Established: August, 2009, Reviewed/Revised: November, 2009, Next Review/Revision Date: March 2010 z. SOP NR200-114, Neurological Assessment, Date Established: (not listed), Reviewed/Revised: November, 2009, Next Review/Revision Date: March 2010 aa. SOP NR200-122, Administering Enteral Feedings/Medications and Care of Gastrostomy or Jejunostomy Tube, Date Established: November, 2009, Next Review/Revision Date: November, 2010 bb. SOP NR100-13, Seizure Management, Date Established: August, 1987, Reviewed/Revised: December, 2007, Next Review/revision Date: December, 2008 12. Health and Human Services Enterprise, Position Description for Nurse and III 13. RGSC MR Nursing Schedule, February and Work Schedule – obtained onsite 14. Texas Department of Aging and Disability Services, Supported Living Center Policy: Use of Restraint, Policy Number: 001, Date: 08/31/09, Supersedes: Essential Elements 15. RGSC Mental Retardation Services Manual, Standard Operating Procedure (SOP), MR 400 02, The Use of Restrain, Revised: November 2009 16. RGSC Restrain Use Summary Report (all restraints) since 7/1/2009 17. RGSC "Stat" Meds" MR only, 7/1/2009 through 2/5/2010 18. Texas Department of MHMR – RSC, MR Client Restraint Report, 7/1/2009 through 2/5/2010 19. RGSC Incident or Injury Report since 7/1/2009 20. RGSC Mental Retardation Services Manual, SOP MR 800 10, At Risk Individuals, Date Established: March 2009, Revised January 2010 21. RGSC Health Risk Assessment Tools, POR-71, Updated 11/09RGSC Health Status Risk Level (High,

	Medium, and Low) Report, printed 2/2/2010 22. RGSC Medication Management Processes Annual Evaluation FY09 23. RGSC List of Individuals Prescribed Psychotropic Medication and Psychotropic Medication Regimen, printed 2/5/2010 24. RGSC Mental Retardation Services, Plan for Professional Services, Revised: 11/07 25. RGSC Nursing Manual, SOP NR100-13, Seizure Management, Date Established: August, 1987, Revised: December, 2008 26. RGSC Seizure Records, Individuals #39, #19 27. RGSC MR Nursing Staff Monthly Meeting, 7/17/09, 8/12/09, 9/8/09, 10/21/0911/18/09, and 12/16/09 28. RGSC Emergency Box Contents – obtained onsite 29. RGSC Mock Emergency Drills Procedure, (DADS Policy), Revised: 03/07 30. DADS Policy, Mock Emergency Drills Procedure, Revised: 10/18/07 31. RGSC Mock Medical Emergency Drill Reports, La Paloma, El Palisano, and Vocational Area 32. Training Due/Delinquent – Employees, as of Print Date through 02/28/10 33. RGSC Medical/POI Audit, Month: December 09, Sample of 3 records 34. RGSC Nursing MR, QA Audit for September, October, and November, 2010 35. RGSC PSP Addendum, Health Status Reviews, Individual #47, 11/4/09, 1/5/10, 2/3/10, 36. RGSC Hospital Visits/Admissions, 1/5/06 through 2/5/10 37. RGSC Mental Retardation Services Manual, SOP MR 500 01, Physical Nutritional Management, Date Established: December 2003, Revised January 2010 38. RGSC Physical and Nutritional Management Team Meeting Minutes, 7/20/09, 8/31/09, 10/19/0911/20/0912/14/09, and 2/10/10 39. RGSC/STHCS Nursing Manual, SOP NR100-59, Medication Administration: Rules/Responsibilities, Established August, 1987, Reviewed/Revised: December, 2007, Next Review/Revision Date: December, 2008 40. RGSC/STHCS Pharmacy Department, Medication Error Policy, Date Established: September, 2001, Reviewed/Revised: December 2007 41. RGSC Medication Error by Process Node, 9/08 through 9/09 – Graph 42. RGSC Medication Error Reports Filed vu Med Investigations by month, 8/08 through 9/09 – Graph 43. RGSC Med Errors by Category FY09 – Graph 44. RGSC Pharmacy Audit Report, June 15 and 16, 2009, Submitted By, Ann L. Richards, Pharm. D. 45. RGSC Medication Management Meeting Minutes, 7/30/09, 8/24/09, 10/27/09, 11/23/09 46. RGSC Pharmacy and Therapeutic Sub-Committee Meeting (MR Minutes), 9/23/09 47. RGSC/STHCS Medication Management Processes Annual Evaluation FY09 48. RGSC Medication Error Event Reports, 02/04/09 for Medication Errors Reported 10/08/09 through 01/15/09 49. RGSC Medication Administration Record Audit Tool, started 11/2009 50. RGSC Environment of Care Manual, Surveillance, Prevention and Control of Infection Manual 51. RGSC Infection Control Curriculum and Competency-based testing Material, based on Texas Department of Health requirements 52. RGSC Infection Control Policies and Procedures: Infection Control Plan, Infection Control Program,

	Position Description/Performance Evaluation, Annual Competency Clinical Skills Assessment, Monthly Data Tally Sheet, Performance Improvement Indicators, Quarterly Performance Improvement Indicator Report Form, Visitors and Traffic Control, Guidelines for Infection Control for Construction and Renovation Projects, Stand of Care Policy, Infection Control Surveillance Log, Infection Control Monthly Report, Infection Control Admission Policy, Inpatient/Client Immunization Program, Environmental Surveillance Techniques, Infection Control Precautions/Universal Precautions Standards Precautions, Hand hygiene/Hand Washing Frequency, Acquired Immunodeficiency Virus Syndrome, Infections Guidelines, Report of Suspected Infection, Multi-Drug Resistance Organism (MDRO) Precautions, Employee Health Program, Employee Health Medical Records Policy and Procedure (ELMO), Access to Confidential Employee Health Medical Records and Exposure Records Policy and Procedure, Employee Health Program Description/Performance Indicators, Report of Employee Infections, Employee Absence and Reporting of Illness or Injury, Employee Immunizations, Hepatitis B Vaccination Program, Tuberculosis Elimination Program, TB Elimination Program Follow-up Plan, Exposure Control Plan, Occupational Post-Exposure Management Plan, Guidelines/Protocols for Occupational Exposure to Blood or Body Fluids, Latex Sensitivity, Wellness Program, Infection Control Practices for Clinical Lab, Cleaning and Defrosting of Refrigerators, Storage of Patient Food in Hospital Refrigerators, Storage of Employee Food in hospital Refrigerators, Outdates and Dated Items, Environmental Services for Outdoor Activity Areas, Cleaning Patio and Pavilion Areas, Procedures for Laundering and Contaminated Patient Clothing, Prevention Patent Pedal Infection , Procedures for Disinfecting Contaminated Instruments, Bioterrorism Protocol for Infection Control, Medical Waste Management Plan, Management of Waste by Department, Treatment and Prevention of Pediculosis and Scabies, Pandemic Flu Control Plan, and DSHS Pandemic Respiratory Infectious Disease Readiness Plan 53. RGSC/STHCS Infection Report, July Forth Quarter 2009, August Infection Report Forth Quarter 2009, September Infection Report First Quarter 2010, October First Quarter 2010,November First Quarter 2010, December Infection Report Second Quarter 2010 54. RGSC/STHCS – MR: Hand Hygiene Observations Tools, 7/21/09, 6-2 Shift,09/30/09,6-2 Shift, 12/24/09, 10-6 Shift and 01/04/10, 2-10 Shift 55. RGSC Infection Control Surveillance Checklists, 06/16/09, 06/15/09, 07/21/09, 09/30/09, 10/07/09, 10/21/09,12/24/09 56. RGSC Departmental Performance Measures, Department, Employee Health, Fiscal Year 2010, First Quarter 57. RGSC/STHCS, Healthcare Associated Infection Rate, First, Second, Third, and Forth Quarter 58. RGSC/STHCS Safety/Risk Management/Infection Control Committee Meeting Minutes, 07/09/09, 08/12/09, 09/25/08, 10/09/08, 11/13/08, and, 12/11/08 59. Partial Records Reviewed: Individuals #47, #108, #51, #39, #8, and #101 **People Interviewed:** 1. Yolanda Gonzalez, RN, Chief Executive Nurse 2. Marcy Valdez, RN, Nurse Manager 3. Jessica Juarez, RN, Quality Assurance Nurse 4. Erlinda Devera, MD, MR Physician 5. Maria G. Dill, MD, Medical Director

	6. Martha Hall, RN, Infection Control Nurse 7. Anne Ikponmwonda, Pharmacy Director **Meetings Attended:** 1. RGSC Health Status Team Committee Meeting, 03/03/2010 2. PNMP Team Meeting, 03/02/10 **Observations:** 1. Tour of Building 501 and 502, medication rooms, treatment rooms, and nurses office, at 10:00 a.m., 03/02/10 2. Nursing Shift Change Report, Building 502, at 1:30 p.m., 03/02/10 3. Medication Administration Observation, Building, Building, at 12 noon, 03/02/10 4. Enteral Nourishment Observation, Individual #47, Building 502, at 3:00 p.m., 03/02/10 5. Medication Administration Observation, Building 502, at 4:00 p.m., 03/03/10 6. Enteral Nourishment Observation, Individual #47, Building 502, at 4:00 p.m., 03/03/10 7. Dining Observation, Supper, Building 501, 03/01/10 **8.** Dining Observation, Supper, Building 502, 03/2/10
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: RGSC has 13 positions allotted for registered nurses (RNs); of those six were vacant. Ten positions were allotted for Licensed Vocational Nurses (LVNs); of those, three were vacant. The facility relies on agency nurses to fill vacancies. Two Nurse III positions have been approved. The Chief Executive Nurse was recruiting and interviewing for both positions. There were no Shift Supervisors for the 6-10 and 10-6 shifts. Having adequate nursing staff is critical to providing clinical care to the individuals who reside at RGSC. The nursing department did not utilize an acuity assessment system on which to base staffing patterns. There were no formalized policies and procedures regarding minimum staffing patterns. RGSC's Nursing Policies and Procedures Manual was reviewed in its entirety. The content in these policies and procedures indicated they were not in alignment with the SA or HCG nor were they in alignment with the recently revised and/or developed statewide nursing workgroup documents. The nursing department did not have an internal peer review system in place to monitor quality of nursing care, to quickly identify deficiencies, or to take prompt corrective action. The records were extremely disorganized. Some of the documentation was contained in the CWS computerized system and some was in the records. The current procedure is to enter the integrated progress notes into the CWS system. Nursing Care Plans were often missing from the records and kept in the nurses' binders. Integrated progress notes and other related nursing documentation was difficult to locate for review in the facility's record keeping system and was not conducive to completing meaningful

	record reviews. RGSC's nursing staffs' competency-based training did not include specialized training in many of the diagnoses or conditions associated with individuals with intellectual and developmental disabilities and physical and nutritional management. RGSC's Nursing Annual and Quarterly Assessments were completed as scheduled according to their PSP calendar. However, the sections listing lab values, diagnostic tests, consults, and system reviews failed to document substantive information in their respective comment sections describing clinical outcomes. Nursing needs to include this information in annual and quarterly reports. As a result of the limited assessment information contained in the records, as identified above, Nursing Care Plans (NCPs) and/or HMPs were not adequate to meet individuals' total health care needs. RGSC's nurses were not present in the dining rooms during mealtimes. According to current policy, RNs are only required to make one dining observation per month. If an individual experiences difficulties while eating, it is the PNAs' responsibility to determine whether or not the severity of the individual's difficulty rises to the level necessary for assessment by a nurse. RGSC diagnostic medical equipment needs up graded. Blood pressure instruments were non-professional and inaccurate; of the two EKG machines, one did not work and the other worked only part of the time. The manual exam table was not easy for individuals to get onto or off of. Emergency equipment incomplete and was not contained on a crash cart or backpack for ready access. The current policy/procedure for conducting Medical Emergency Drills only includes the use of three scenarios--respiratory distress, cardiac arrest, and foreign body airway obstructions. These scenarios need to be expanded to include other scenarios that would warrant the demonstration of emergency procedures. The facility does not have an Emergency Management Committee to review, analyze, track, and trend drill performance. Findings of the Mock Emergency Drill reports are filed with the Incident Management Coordinator but there is not a clear system in place that promotes the discussion, analysis and tracking of the drill results. The nurses were responsible for scheduling ordered or recommended health related appointments. There was no centralized tracking system in place to ensure that health related appointments were kept or that appointments missed or refused were rescheduled in a timely manner. Since there was no centralized tracking system it was not possible to track refused and missed appointments. Individuals had Nursing Annual and Quarterly Assessments completed as scheduled according to their PSP calendar. However, the sections listing lab values and diagnostic tests, consults, and system reviews failed to contain substantive information documented in their respective comment sections describing clinical outcomes, (e.g., whether the individuals' health status were progressing, maintaining, or regressing, strategies that are working or not working, and to recommend changes, if indicated, in strategies, support

	and/or services). During dining observations nurses were not present in the dining rooms. According to current policy, RNs are only required to make one dining observation per month. If an individual experiences difficulties while eating, it is the direct care staffs' responsibility to determine whether or not the severity of the individual's difficulty rises to the level necessary for assessment by a nurse. The nursing staff did not receive competency-based training on Physical and Nutritional Management. Yet, by policy they are responsible for completing monthly dining monitoring observations to use in there quarterly nursing assessment. The nursing staffs were also required to participate on the Physical and Nutritional Management Teams. It is questionable how the nursing staff can adequately assess, develop plans for care, and monitor individuals' Physical and Nutritional Management issues without this specialized training. As a result of the limited assessment information contained in the records, as identified above, Nursing Care Plans (NCPs) and/or Health Maintenance Plans (HMPs) were not adequate to meet individuals' total health care needs. There needs to be a monitoring system in place to ensure that NCPs and/or HMPs meet individuals' total health care needs, interventions are appropriate, implemented, and their effectiveness evaluated. During the medication observation nurses were observed using the picnic style plastic spoons to administer medications mixed with food stuffs. The nursing staff should work with the Physical and Nutritional Management staff to identify individuals that might be at risk for involuntary biting into a plastic spoon while receiving medication. For these individuals the Facility should consider use of hard plastic spoons for their administration of medication. The Medication Administration Records (MARs) did not include any per necessary (PRN) medications. The staff nurses reported that the facility does not use standing PRN orders even for management of status epilepticus. If PRN medications were needed the physician was called for an order. Individuals' pictures placed in the MAR were of poor quality. Many of the individuals' pictures were taken when the individual was much younger and were hardly recognizable. The MARs did not contain the individual's PNMP, nor were special needs for alternate texture, consistency, oral presentation techniques, adaptive equipment, and/or positioning listed on the MARs. Copies of lists indicating individuals who required special consistency and/or who needed pills crushed were posted on bulletin boards in the medication rooms. This is not adequate because nursing staff may fail to look at the bulletin boards or the lists may not be updated. Such omissions have the potential to cause harm, (e.g., swallowing difficulty leading to aspiration).

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	The facility's Chief Executive Nurse (CEN) was responsible for RGSC and South Texas Health Care System (STHCS) nursing services. The nursing department had one Nurse Manager who was supervised by the CEN. RGSC's Registered Nurse (RN) and Licensed Vocational Nurse (LVN) staffing data showed that they had 13 positions allotted for RNs with six RN vacancies, and 10 positions for LVN with three vacancies. Due to the vacancies the facility needed to utilize the services of agencies to augment nursing staffing coverage. Recently, two new Nurse IV positions were established. One position will serve as an Infection Control Nurse and Nurse Educator; the other will serve as a Nursing Operational Officer and Hospital Liaison Nurse. The present Infection Control Nurse provided services to both **S**THCS and RGSC. The CEN reported that she was in the process of recruiting and interviewing nurses for these positions. In addition, the CEN stated recruiting and retaining nurses for RGSC was a challenge for a variety of reasons, (e.g., many nurses interviewed elect to work at STHCS, the state system had no parity for salaries or other incentives, does not pay for overtime and instead provides compensatory time). The facility regularly had nursing students from the local nursing schools assist while they earned clinical training, however, this did not make a significant difference in the facility's ability to recruit and employ new graduates. The facility should continue its efforts in recruiting and maintaining a stable nursing staff. The facility had two residential buildings that provided 24-hour nursing care. Typically, there were 15 nurses allocated for residential services, seven RNs, including the Nurse Manager, and eight LVNs. The facility did not have Nursing Shift Supervisors. There were no RNs, only LVNS, scheduled on the 10-6 shift. The CEN reported that if a RN is needed either the Nurse Manager or the STHCS' RN is called. The CEN further reported that the nursing department was moving toward a case management system utilizing five RNs with a divided caseload of individuals. In reviewing the February and March 2010, MR Nursing Schedules, assignments were made based on staffing availability and were adjusted throughout the month to meet minimum staffing requirements. Formal policies and procedures were not available to address minimum staffing requirements nor were data available to indicate whether or not the facility had met such requirements. The nursing department did not utilize an acuity assessment system. Acuity rating systems are useful in making rational decisions regarding nursing staffing assignments, (e.g., number of nurses needed in a particular home or unit, number needed per shift, and the ratio of RNs to LVNs, etc). The nursing department should develop and implement policies and procedures to establish minimum staffing patterns and acuity assessments. The facility had few monitoring systems in place to assess nursing care and clinical outcomes at the time of the monitoring team's review. The CEN and Quality Assurance	

#	Provision	Assessment of Status	Compliance
		(QA) Nurse reported that numerous nursing monitoring tools had been developed. Copies of those tools were requested but not received. The (QA) Nurse recently developed a Medical/POI QA Audit Tool designed to meet the SA and HCG for Sections: G - Integrated Clinical Services, H – Minimum Common Elements of Clinical Care, J – Psychiatric Care and Services, L – Medical Care, M – Nursing Care, N – Pharmacy, O – Physical and Nutritional Management, and Q Dental Service. A threshold of 100% was established for compliance. The Medical/POI QA Audit Tool was completed for the December, 2009 review period and was used for the review of three records for the above sections. The comment section of the audit tool described causes of compliance failures. However, it did not evaluate the quality of care or make recommendations for corrective actions. Audit reports were given to the respective discipline for follow-up and corrective action. The facility needs to cross-walk the recently developed audit tool with the SA and HCG to ensure that all areas required for compliance are addressed. The tool also needs to address quality of care provided by clinical disciplines and make recommendations for corrective action. The QA department needs to analyze, track and trend clinical performance data to identify areas of practice to ensure non-compliant practices demonstrates improvements. Many nursing practices requiring corrective action were included in the Nursing Staff Monthly Meeting minutes, July through December, 2009: compliance issues were identified and discussed; recommendations for corrective actions made; responsible staff assigned to tasks; and, date for completion. Issues that required follow up through resolution were not consistently reported in the subsequent monthly meeting minutes. In addition, no documentation was found analyzing effectiveness of corrective actions or interventions implemented. As nursing develops and implements additional monitoring tools and generates additional clinical data, the Nursing Staff Meeting minutes need to include significant findings from these tools making it a succinct document. The nursing staff needs to develop and implement a system to analyze, track, and trend data that identifies areas where nursing practices needs improvement. The nursing department did not have an internal Nursing Peer Review System to monitor nursing practices. Nursing audits were completed by the QA Nurse. An internal Peer Review System could serve to improve quality of services and enhance skills and practices of nurses. The nursing staff did not have a clear understanding of the SA and HCG requirements, although they were working on their section of the Plan of Improvement (POI). Cross-walking the draft SA Monitoring Tools with the SA and HCG would help the nursing staff better understand the expectations for compliance and would be helpful in revising and/or developing their own audit tools. The nurses did not have a process to review their practices and performance against the SA and HCG. The nursing department needs to develop and implement an effective internal peer review	

#	Provision	Assessment of Status	Compliance
		process. Although the facility has a policy for Nursing Peer Review, the process described is more investigative than educational. Regular peer reviews should focus on the identification of strengths and weaknesses of nursing practices, with analyses of nursing practices, and identification of problematic trends with plans of correction directed toward problems identified. An internal Peer Review System would serve to improve quality of services and enhance skills and practices of nurses. The nursing department needs to develop and implement an effective internal peer review process. Review of the facility's Nursing Manual, SOP NR100-03, Nursing Competency Policy, Date Established: October, 1998, Reviewed/Revised: February, 2010, Next Review/Revision Date: March 2010, was geared for both the RGSC and STHCS. While much of the orientation and ongoing training was applicable for both mental health and intellectual and developmental disability nursing, the policy did not adequately meet the competency-based training needed by nurses who provide care for individuals with intellectual and development disabilities. The following training items were not in the policy as part of the orientation and ongoing training: • Co-morbid chronic and acute conditions that often occur within the intellectual and developmental disability population, (e.g., seizure management, gastro esophageal reflex disease, osteoporosis, bowel management, aspiration pneumonia, urinary tract infections, chronic oral hygiene, and dental conditions, etc.), • Information on Intellectual and developmental disabilities, (e.g., mental retardation, Down Syndrome, pervasive developmental disorder, autism spectrum disorder, Rett syndrome, Asperger's syndrome and many more such conditions), • Physical and Nutritional Management, • More detail regarding the completion of comprehensive Annual and Quarterly Nursing Assessments, Nursing Care Plans and Health Maintenance Plans is needed, and • The requirement that all training should be competency-based; evaluated by a qualified instructor as opposed to self-assessment of competency should be stated. While touring in buildings 501 and 502 nursing offices and the medication and treatment rooms, the diagnostic and treatment equipment was checked. The two treatment rooms contained Electrocardiogram (EKG) machines. The nursing staff reported that one machine does not work and the other machine only works some of the time and is not considered reliable. Accurate and reliable EKG machines are a vital diagnostic instrument in assessing individuals' cardiac status, particularly at this facility because of the numerous medications that require an EKG assessment prior to prescribing. The facility should replace these two EKG machines with portable, fully functioning, and	

#	Provision	Assessment of Status	Compliance
		reliable machines. The nursing staff typically use non-professional equipment [e.g., drug store variety, wrist blood pressure (B/P) apparatuses for taking B/P assessment], because the individuals are often resistant to allowing the use of professional models with an arm cuff. The nurses reported that the wrist type blood pressure apparatuses were not accurate. While discussing this issue with the nursing staff a comparative measure was made between the wrist type and the professional arm cuff. The wrist type B/P apparatus measured 30 millimeters of mercury (mmhg) higher for both systolic and diastolic B/P than the professional model with an arm cuff. It is vitally important for nursing staff to have professional quality, accurate, and reliable diagnostic equipment, such as pulse oximeters, thermometers, and weight scales. As with all diagnostic equipment they must be cared for properly, routinely checked for calibration, and checked for proper working order. The nursing department should check all diagnostic equipment for calibration and working order. Items that are not reliable and/or not working should be replaced. Those items when replaced should be removed from stock so that they will not be accidentally used. The exam tables in buildings' 501 and 502 nurses' treatment rooms were high manual tables without safety devises. Most power operated tables can be lowered as low as 18 inches. The lower table makes it easier for the individual with mobility problems to get on and off and can serve to lessen the anxiety of an insecure individual. Individuals can get onto and off the exam table with less assistance, helping them maintain their dignity. The facility should replace the manual exam tables with electrically powered exam tables. While touring buildings 501 and 501, emergency equipment was checked. The emergency equipment was kept in separate areas of the nursing offices. The facility does not keep emergency equipment on a crash cart or in a portable backpack style container. The emergency equipment failed to contain a portable oxygen tanks, suction machines or yankauer suctions. Dr. Dill was informed of the lack of oxygen tanks in these buildings. She stated that portable oxygen tanks were available in the STHCS section of the facility. She agreed to supply each building with portable oxygen tanks. Nurses should receive competency-based training in the use of the oxygen tanks. The tanks should be checked daily to ensure they are adequately filled and in proper working order. The facility should consider placing all emergency equipment, supplies and medications (unless the medication requires refrigeration) on a crash cart or in a portable backpack style container for ready and rapid transport to the scene, whether for a drill or real "code." Review of the Emergency Equipment Checklists, indicated a staff signature was present	

#	Provision	Assessment of Status	Compliance
		for each day from February 1 through March 2, 2010. However, the checklist sheet did not list each item of the emergency equipment. The Emergency Equipment Checklist should be revised to include all emergency items. Nurses should check each item daily to ensure it is in good working order. Nurses responsible for checking emergency equipment should be re-trained to ensure they can competently check and operate all emergency equipment. Review of Training Due/Delinquent – Employees report dated February 28, 2010, indicated that two employees were delinquent in CPR training since 2007 and one of the two employees was delinquent in Emergency Response Training since 2007. The facility needs to review their training records and ensure employees delinquent in CPR and Emergency Response Training are brought up-to-date. The Mock Emergency Drills Procedure, Dated: 02/07, Revised: 03/07, adapted from the DADS' policy, stated, "Each home will participate in one drill, per shift, per month, Vocational Services and other program areas consumers routinely attend will participate in one drill, per shift, per site, per month." This policy differs from the Mock Emergency Drills Procedure, Revised: 10/18/07, which states, "Drills must be conducted in every home, shift, and vocational setting each quarter. In addition, a drill will be conducted in the following settings once per year; the kitchen, a vehicle, and in the administration area. These can be conducted at any time during the year as all of these scenarios are tested." The facility should review their Mock Emergency Drills Procedure to ensure they are operating on the most recent revision and that the policy is compliant with generally accepted professional standards of care. Review of the Mock Medical Emergency Drill sheets received in the document request indicated that the following drills were completed and passed: • La Paloma – 09/19/09 at 2:00 p.m. • El Palisano – 09/19/09 at 1:12 p.m., 09/26/09 at 5:01 a.m., and 11/09/09 at 3:10 p.m., 11/14/09 at 10:25 p.m. • Vocational – 09/30/09 at 9:56 a.m. La Paloma was missing September quarter drill reports for the 10-6 and 2-10 and all of the next quarter reports. El Paisano was missing September drill report for the 6-2 Shift and the next quarter reports. It may have been a misunderstanding with the document request for six months of Mock Emergency Drill reports and all drill reports may not have been sent for review. All the drills reviewed were considered passed, however, on El Paisano's 11/19/09 at 3:10 p.m. Mock Emergency Drill report, in the Comments/Concerns section stated, "No staff were in the lobby area. When a staff arrived it took them a while to respond." There were no corrective actions recommended on the form by the staff calling the drill. The check block, stating, "Every	

#	Provision	Assessment of Status	Compliance
		staff member in the area responded immediately to the scene", was not marked. According to facility policy this should have been considered a failed drill, and corrective action should have been recommended. The Mock Emergency Drill Procedure did not indicate the requirement that facility physicians participate in the drills nor did the Mock Emergency Drill Sheets indicate that a physician participated. The facility staff needs to be properly trained on the completion of the Mock Emergency Drill reports. Also, the facility staff needs to ensure that recommended corrective actions have been performed and documented. The current policy/procedure for conducting Medical Emergency Drills only includes the use of three scenarios, e.g., respiratory distress, cardiac arrest, and foreign body airway obstructions. These scenarios need to be expanded to include other scenarios that would warrant the demonstration of emergency procedures. The facility does not have an Emergency Management Committee to review, analyze, track, and trend drill performance. Findings of the Mock Emergency Drill reports are filed with the Incident Management Coordinator but there is not a clear system in place that promotes the discussion, analysis and tracking of the drill results. The nurses were responsible for scheduling ordered or recommended health related appointments. Appointments were written the on nurses' Nursing Events Daily Log and then written on a large calendar posted on the inside back of a door in the nurses' station. It was not possible to discern if or how appointments were rescheduled. There was no centralized tracking system in place to ensure that health related appointments were kept, or appointments missed or refused were rescheduled in a timely manner. Since there was no centralized tracking system it was not possible to track refused and missed appointments. The facility needs to develop and implement a scheduling and tracking system to ensure that health related appointments were scheduled as recommended, missed and/or refused appointments were rescheduled, and appointments were tracked through to completion. The facility's Infection Control and Employee Health Department functions were directed by the Medical Director and carried out by an Infection Control Registered Nurse. The Infection Control Nurse was responsible for both RGSC and STHCS. The CEN reported that one of the two recently established nursing positions will assume the responsibility for RGSC's infection control services. The CEN was actively recruiting for this position. The facility's Infection Control Policy and Procedures apply to both RGSC and STHCS. Review of their Infection Control Policy and procedures indicated they were reviewed and updated between August and November, 2009. The Infection Control Policy and	

#	Provision	Assessment of Status	Compliance
		Procedures were adapted from the Texas Department of Aging and Disability Services, State Supported Living Centers Procedure: Infection Control Policy and Training, and Competency Testing Materials. Infection Control training content was based on requirements from the Texas Department of State Health Services. An overview of the facility's exposure control plan, responsibilities related to infection control, and the procedures for standard precaution task were covered. Hand washing was covered in detail. Review of the facility's Training Due/Delinquent – Employees List indicated that one employee was delinquent over a year in Infection Control training. Review of the facility's Infection Control program indicated that the basic areas regarding the surveillance of MRSA, Hepatitis a, B and C, H1N1, C-Diff, STDs, and HIV Positive Tuberculin Skin Test, Immunizations, and antibiotic use was regularly entered into a computerized database. A procedure was in place for notification of infectious diseases for Texas. Review of the Infectious Disease List indicated one positive culture for MRSA on 03/06/09, treated with Bactrim, with a negative culture on 03/29/09. Since this report occurred prior to the SA, the record was not reviewed. Review of Monthly/Quarterly Infection Reports, July through December, 2009, indicated that nosocomial rates were 0% except for November, 2009, where a nosocomial rate of 1% was reported related to upper respiratory infections and urinary tract Infections. There were no reportable diseases identified during the reporting period reviewed. Review of the Monthly Safety/Risk Management/Infection Control Committee minutes, July through December, 2009, reported the raw data relating to percentage of infections, nosocomial and reportable disease. The Medical Director reported that the facility experienced a high incidence of pneumonia in 2008. As a result, the Infection Control Nurse reviewed each individual's record for status of pneumococcal vaccination and found there was a lack of vaccinations. Consequently, all individuals needing the pneumococcal vaccinations were immunized. The immunization status for all individuals was entered into a computerized database for tracking and updating according to recommended preventative health schedules. In 2009 the incidents of pneumonia was significantly reduced. A copy of the information reported above was requested, but not received. The facility failed to have a formalized system in place to routinely analyze, track and trend data, and to develop and implement plans to correct problematic areas related to infection control measures. Review of the facility's Environmental Surveillance Reports, July through December, 2009, indicated that the Infection Control Nurse surveyed all areas of the facility for infection control issues according to policy. Recommendations were made to	

#	Provision	Assessment of Status	Compliance
		appropriate facility staff for corrective action to areas of deficiencies. However, no follow-up information was available to ensure that recommendations were carried out. Review of the facility's Hand Hygiene Observation Tools, July through December, 2009, indicated that the Infection Control Nurse completed hand washing observations on each shift. No deficiencies were identified. Review of the facility's Employee Health Department Performance Measures, Fiscal Year 2010, 1st Quarter, for the reporting period of September, October, and November, 2009, indicated that they are working towards a computerized employee health record. The Employee Health Department utilizes the following indicators for monitoring employees' health: Tuberculosis (TB) status of employee population, monitoring and assessing influenza immunizations for identified employee populations, and Hepatitis B immunization status of employee population. This information was reported to the Performance Improvement Council (PIC) on a quarterly basis. According to the report, TB skin tests are continually repeated on an annual basis. During the reporting period two positive results were on employees who had a history of Bacillus Calmette-Guerin (BCG), a vaccine against TB, with subsequent negative chest x-rays. The report indicated there was no trend analysis available at the time. This issue will be reviewed in more depth in the next tour.	
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.	Review of Individuals #47, #108, #51, #39, #8, and #101showed Nursing Annual and Quarterly Assessments completed as scheduled according to their PSP calendar. However, the sections listing lab values and diagnostic tests, consults, and system reviews failed to contain substantive information documented in their respective comment sections describing clinical outcomes, (e.g., whether the individuals' health status were progressing, maintaining, or regressing, strategies that are working or not working, and to recommend changes, if indicated, in strategies, support and/or services). Nursing needs to include this information in annual and quarterly reports. Annual and Quarterly Nursing Assessments enable the nurse to make comparisons of individuals' health status from quarter to quarter, culminating in a comprehensive annual assessment containing relevant information that contributes to developing health maintenance plans(HMPs) and provides the PST information from which to develop PSPs.	
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,	All health care issues identified in Annual and Quarterly Assessments should have nursing interventions until resolved. This would include PNMPs and enteral nutrition. This was not always the case. For example, dining observations were completed during supper meals in buildings 501 and 502, respectively on 03/01/10 and 03/02/10. Nurses were not present in the dining rooms during dining. According to current policy, RNs are only required to make one dining observation per month. If an individual experiences	

#	Provision	Assessment of Status	Compliance
	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.	difficulties while eating, it is the PNAs' responsibility to determine whether or not the severity of the individual's difficulty rises to the level necessary for assessment by a nurse. Based on multiple observations, PNAs do not seem to be knowledgeable regarding risks factors associated with dining (e.g., coughing, coughing with struggle, and failure to clear airway that could indicate aspiration). This was demonstrated by Individuals #63 and #5 who experienced repeated coughing or coughing with struggle (tearing, face turning red, wet vocal sound, etc.) during their meals. In each situation the monitoring team called these conditions to facility staffs' attention with the request that a nurse assess these individuals. Individual # 63's PNMP indicated a risk for choking and required meat to be cut into bite size. Individual #63 was served a whole piece of sliced meat. The tomatoes served were cut vertically into large 4 to 6 pieces. According to #63's PNMP, whole fruit was acceptable. Individual #63 was observed eating large pieces of meat and whole slices of tomato. Staff were not observing or assisting this individual during dining. Monitoring team notified the residential staff and supervisor of the need for assistance in cutting up food into bite size pieces and the need to review the PNMP for appropriate bite sizes of all foods. They indicated action would be taken to review the PMNP. Individual # 5 was observed talking and coughing while dining that resulted in five episodes of coughing, with one episode resulting in coughing with struggle. Although individual #5 had a 1:1 staff, the staff did not recognize coughing and/or coughing with struggle as being significant. Individual #101 was observed grabbing a large dinner roll off another individual's plate, and stuffing half of it into his mouth as he exited the dining room. It happened quickly before his 1:1 staff could stop him. Monitoring team member immediately notified the residential supervisors, who without struggle removed the roll, calmly had him sit down and allowed him to masticate the roll. Had an inexperienced staff attempted to remove the roll he might have crammed the whole roll in his mouth and tried to swallow it, which could have resulted in choking. Review of Individual #101's PNMP indicated he grabs food. However, the PNMP did not include behavior intervention strategies for food grabbing. Individuals with 1:1 staff and/or those who required assistance were observed with their staff standing. The dining rooms failed to have stools for the staff set at eye level so that when assisting with dining the staffs are better able to monitor the individual. Even if the individual's 1:1 staff were not assisting the individual the staff should not be standing over them while they dine making the individual uncomfortable. The nursing staff did not receive competency-based training on Physical and Nutritional Management. Yet, by policy they are responsible for completing monthly dining monitoring observations to use in their quarterly nursing assessment. The nursing staff were also required to participate on the Physical and Nutritional Management Teams. It	

#	Provision	Assessment of Status	Compliance
		is questionable how the nursing staff can adequately assess, develop plans for care, and monitor individuals' Physical and Nutritional Management issues without this specialized training. In addition, when individuals experience swallowing difficulty during dining, it is the PNA who determines if the problem is severe enough to contact nursing staff. Once contacted the nurse determines if the problem is severe enough to contact the physician and make a referral. After making the two dining observations it was apparent that the PNAs do not have the knowledge or skills to recognized signs and symptoms of individuals having swallowing difficulties. Because the PNAs were busy serving food during mealtime, and getting individuals in and out of the dining room, they were not observing or assisting individuals closely enough to prevent or recognize when an individual needed assistance with dining or experienced problems. The staff were rarely observed looking at the PNMPs. Review of RGSC's Nursing Services, SOP NR-100-22, Administering Enteral Feedings/Medications and Care of Gastrostomy or Jejunostomy Tube Date Established: November 2009, found it met current nursing standards of practice. There was only one concern identified regarding, procedure: II., B. "G-tube will be replaced by the RN …" The nursing staff responsible for reviewing and revising procedures should add safety precautions directing RNs to only replace the G-tube after the percutaneous tract is well healed. Enteral Feeding Observations were completed for Individual #47 on, 03/02/10 at 3:00 p.m. The nursing staff on followed correct procedure for administering bolus enteral feeding via G-tube. As she checked Individual #47's residual and found that he had greater than 60 cc of residual, the nurse correctly withheld the feeding, was to recheck residual later to ensure there was no greater than 5 cc of residual before administering the bolus enteral feeding. The staff nurse was observed administering bolus enteral feeding via G-tube on 03/03/10 at 4:00 p.m. The staff nurse administered the feeding correctly according to procedure.	
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.	Individuals #47, #108, #51, #39, #8, and #101, had Annual and Quarterly Nursing Assessments completed as scheduled according to their Personal Support Plan (PSP) calendar. The sections listing lab values, diagnostic tests, consults, and system reviews failed to document substantive information in their respective comment sections describing clinical outcomes, (e.g., whether the individuals' health status were progressing, maintaining or regressing, strategies that were working or not working, and recommended changes, if indicated, in strategies, support and/or services). Quarterly Nursing Assessments enable the nurse to compare individuals' health status from quarter to quarter, culminating in a comprehensive annual assessment containing	

#	Provision	Assessment of Status	Compliance
		relevant information that contributes to developing health maintenance plans(HMPs) and provides the Personal Support Team (PST) information from which to develop PSPs. Nursing needs to include in their quarterly and annual assessments information from comment sections that describes clinical outcomes, (e.g., whether the individuals' health status were progressing, maintaining or regressing, strategies that were working or not working, and recommended changes, if indicated, in strategies, support and/or services). As a result of the limited assessment information contained in the records, as identified above, Nursing Care Plans (NCPs) and/or Health Maintenance Plans (HMPs) were not adequate to meet individuals' total health care needs. There needs to be a monitoring system in place to ensure that NCPs and/or HMPs meet individuals' total health care needs, interventions are appropriate, implemented, and their effectiveness evaluated. RGSC's Nursing Policies and Procedures Manual was reviewed in its entirety. Fourteen of the Nursing SOPs were dated as being reviewed/revised March 2010. SOPs NR200-97 and NR200-98 had not been updated since 1992. SOPs NR200-90, NR200-91, NR200-93, NR200-95, NR200-96, NR200-99, and NR200-100, had not been updated since 1998. SOPs NR200-99 (duplicate number but different policy), NR200-101, NR200-102 had not been updated since 2003. SOPs NR200-108, NR200-109, and NR200-110 had not been updated since 2004. SPOs NR200-94 and NR200-100-13 had not been updated since 2008. It is questionable how these policies and procedures could have been thoroughly and adequately reviewed and revised in March 2010, since the SA monitors were at the facility during the week of March 1, through March 5, 2010. Review of the content in these policies and procedures indicated they were not in alignment with the SA or HCG, nor were they in alignment with the recently revised and/or developed statewide nursing workgroup documents (e.g., SOPs NR100-103, NR100-104, NR100-100-105, NR100-106, NR100-107, NR200-108, NR200-109, NR200-110, NR100-111, NR100-112, NR100-113, NR100-114, and NR100-122). The nursing department needs to thoroughly review all nursing policies and procedures to ensure they are in alignment with the SA and HCG. Policies and procedures that are no long operational needs to be purged form the Nursing Policy and Procedure Manual. The records were extremely disorganized. Some of the documentation was contained in the Clinical Work Station (CWS) computerized system and some were in the records. There were times when the nursing integrated progress notes were entered only into the CWS system, and other times when the integrated progress notes were only written in the record. The current procedure is to enter the integrated progress notes into the CWS system. Nursing Care Plans were often missing for the records and kept in the nurses' binders. When the monitoring team asked for the integrated progress notes on individual #108 for the last three months, the QA Nurse stated they would have to be	

#	Provision	Assessment of Status	Compliance
		printed from CWS. When they were printed, it resulted in approximately one and one-fourth inch stack of paper with one single entry by nursing on each sheet of paper. Nursing Annual Assessments were kept in the Program Record, while the Nursing Quarterly Assessments were in the Medical record. Integrated progress notes and other related nursing documentation were difficult to locate for review in the facility's record keeping system and was not conducive to completing meaningful record reviews. The monitoring team understands the challenges involved in migrating to an electronic record system. During this process, documentation still needs to be accessible and usable for making decisions about care. This issue with be further reviewed in future tours.	
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.	RGSC was using the Health Risk Assessment Tool-Nursing Section as the tool for the identification of clinical risk indicators for individuals. The Health Risk Assessment procedure was of concern due to the fact there were no specific and/or clear criteria for determining risk levels The tools asked "yes" or "no" questions for items relating to Cardiac, Constipation, Dehydration, Diabetes, GI Concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. This Health Risk Assessment Tool was not adequate to provide a comprehensive risk assessment for any of the areas listed above, nor did it result in an appropriate identification of clinical risk indicators. The facility did use the standardized BRADEN Scale for assessing skin integrity issues. Professionally recognized standardized health risk assessment tools should be used statewide in all facilities to ensure that accepted professional standards of practice were followed. The Health Risk Assessment Tool needs to be evaluated by the appropriate state and/or facility staff for clear criteria for determining risk to eliminate subjectivity, and to ensure that the Tool meets accepted professional standards of care. Observations were completed at the Health Status Team (HST) Committee Meeting, March 3, 2010. Team members reviewed their respective individuals' Health Risk Assessment information and rating scores. The Nurse Manager demonstrated active participation, verbalized in depth knowledge of health care status and needs of the individuals reviewed (e.g., #47, #108, #8, #31, #19, #12, #91, #5, and #39). She offered appropriate recommendations to the HST for individuals who were identified as needing additional supports and/or services, or modifications in their PSPs. Although the HST members gave their own reports on the above individuals, when reviewing NCP and/or HMP plans there were often inconsistencies and conflicting information identified between nursing and other disciplines as was evidenced by the aspiration NCP for individual #51 that stated he received pureed foods while his Physical and Nutritional Management Plan (PNMP) stated he received chopped foods. Another	

#	Provision	Assessment of Status	Compliance
		inconsistency was identified between individual #51's NCP and PNMP. His PNMP stated he should remain upright one hour after meals and his NPC stated he should remain upright for 30-45 minutes after meals. These examples demonstrate the lack of communication among the interdisciplinary staffs when assessing individuals' health risks and needs when developing discipline specific plans and PSPs. The facility needs to ensure that respective disciplines who plan individuals' care collaborate closely when developing discipline specific plans and PSPs to prevent inconsistencies and conflicting information in individuals' plans of care. Review of the above individuals' PSPs found that the Nursing Section was not printed on the recently revised PSP template. The Nurse Manager was informed of the missing Nursing Section to the PSP template. She agreed to notify the staff responsible for creating/revising the PSP template of the need to add the Nursing Section. Review of PSPs demonstrated a lack of baseline data and substantive content that should be included in discipline specific plans. Typically, the plans were brief failing to state specifically their plans for interventions. If the reader reviewed the individual's PSP without reviewing the discipline specific assessments and plans, it would be difficult to reconcile the two because of the brevity of the PSP. The facility needs to ensure that PSPs contain baseline data and detailed interventions.	
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.	Medication rooms and medication storage areas were checked during the tour in buildings 501 and 502. Topical and oral medications were stored separately. Medications that required refrigeration were stored in a separate refrigerator. No other items were stored in refrigerators containing medications. Refrigerators containing food stuffs to use for individuals were clean and did not contain any personal items. All refrigerator and freezer temperatures were checked daily and checklists initialed. Controlled medications were stored and double locked in the medication carts. Controlled medications requiring refrigeration were stored in a locked box in the medication refrigerator. Reviewed controlled medication check sheets indicated all signatures were present and that on-coming and off-going shift nurses were counting medications together. A limited review for expired medications in the medication and treatment carts, and cabinets did not find any expired or discontinued medications. Medication Administration Observation Passes were completed in building 501 on 03/02/10 at 12:00 noon and in building 502 on 03/03/10 at 4:00 p.m. The nursing staff completed the Medication Administration Passes successfully, according to correct procedure without committing medications errors. During the medication observation nurses were observed using the picnic style plastic spoons to administer medications mixed with food stuffs. The nursing staff should work with the Physical and Nutritional	

#	Provision	Assessment of Status	Compliance
		Management staff to identify individuals that might be at risk for involuntary biting into a plastic spoon while receiving medication. For these individuals the Facility should consider use of hard plastic spoons for their administration of medication, like a "mother's care spoon". Review of the MARs did not identify any missing nursing signatures. The Medication Administration Records (MARs) did not include any per necessary (PRN) medications. The staff nurses reported that the facility does not use standing PRN orders even for management of status epilepticus. If PRN medications were needed the physician was called for an order. Individuals' pictures placed in the MAR were of poor quality. Many of the individuals' pictures were taken when the individual was much younger and were hardly recognizable. The staff nurse reported that the facility was in the process of making new pictures of individuals that will be scanned into the Clinical Work Station, then printed out and old pictures replaced. The MARs did not contain the individual's PNMP, nor were special needs for alternate texture, consistency, oral presentation techniques, adaptive equipment, and/or positioning listed on the MARs. Copies of lists indicating individuals who required special consistency and/or who needed pills crushed were posted on bulletin boards in the medication rooms. This is not adequate because nursing staff may fail to look at the bulletin boards, the lists may not be update, etc. Such omissions have the potential to cause harm, (e.g., swallowing difficulty leading to aspiration). It is just as important that individuals requiring special dining needs receive their medications accordingly to prevent complications. The facility should update individuals' pictures to ensure they are correctly identified when receiving their medications. The list used for individuals requiring alternate texture, consistency, oral presentation techniques, adaptive equipment, and/or positioning should be discontinued and replaced by including this information in their MARs, along with a copy of their PNMP. Review of RGSC's Nursing SOPs NR100-59 through 74, Medication Administration: Rules/responsibilities, Date Established: August, 1987, Reviewed/Revised: December, 2007, Next Review/Revision: Date: December, 2008 and SOP NR100-60, Date Established: August, 1987, Reviewed/Revised December, 2007, Next Review/Revision Date: December, 2008 were conducted. These were not reviewed or revised for over two years. They should be reviewed and revised to ensure that current professional standards of practice are followed and that they are in alignment with the SA and HCG.	

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

1. While it may be absolutely necessary to use Agency Nurses to meet the minimum staffing ratio, it is important to limit their use because Agency nurses may not be as familiar with the individuals as full-time staff. A cost to benefit analysis should be conducted by the Facility to determine the cost of Agency Nurses as compared to hiring more Facility Nurses
2. Nursing should consider staffing with at least one dedicated RN for the residential buildings on the 10-6 shift everyday including weekends and

holidays.

3. The facility needs to have Nursing Shifts Supervisors on all shifts.
4. The facility needs to follow through with the intent to utilize a case management system to divide the caseloads among the RNs.
5. The nursing department should develop and implement policies and procedures to establish minimum staffing patterns and acuity assessments.
6. The nursing department needs to develop and implement an effective internal peer review process.
7. The following training items need to be included in the policy as part of the orientation and ongoing training:
    a. Co-morbid chronic and acute conditions that often occur within the intellectual and developmental disability population, (e.g., seizure management, gastro esophageal reflex disease, osteoporosis, bowel management, aspiration pneumonia, urinary tract infections, chronic oral hygiene, and dental conditions, etc.),
    b. Information on Intellectual and developmental disabilities, (e.g., mental retardation, Down Syndrome, pervasive developmental disorder, autism spectrum disorder, Rett syndrome, Asperger's syndrome and many more such conditions),
    c. Physical and Nutritional Management,
    d. More detail regarding the completion of comprehensive Annual and Quarterly Nursing Assessments, Nursing Care Plans and Health Maintenance Plans is needed, and
    e. The requirement that all training should be competency-based; evaluated by a qualified instructor as opposed to self-assessment of competency should be stated.
8. The nursing staff needs to make more frequent observations during mealtimes. Nurses need to be present during mealtimes to quickly identify, assess, and intervene should individuals experience swallowing difficulties while eating.
9. The facility needs to consider replacing the manual exam tables with electronically powered exam tables.
10. The facility needs to ensure that PNAs are competently trained in physical and nutritional management issues related to assisting individuals during mealtimes and consistently refer to and follow the individual's PNMPs.
11. The nursing staff responsible for reviewing and revising policies and procedures needs to consider adding safety precautions that RNs may only replace the G-tube after the percutaneous tract is well healed to the Nursing Services, SOP NR-100-22, Administering Enteral Feedings/Medications and Care of Gastrostomy or Jejunostomy Tube Date Established: November 2009.
12. The facility needs to place all emergency equipment, supplies and medications (unless the medication require refrigeration) on a crash cart or in a portable backpack style container for ready and rapid transport to the scene, regardless if it is a drill or real "code."
13. The facility's nursing department should check all diagnostic equipment for calibration and working order. Items that are not reliable and/or not working should be replaced. Those items when replaced should be removed from stock so that they will not be accidentally used. Specifically the two EKG machines in buildings 501 and 502 should be replace by EKG machines with portable, fully functioning, and reliable machines.
14. The facility needs to ensure that buildings 501 and 502 are equipped with portable oxygen tanks for emergency response.
15. The facility needs to revise the Emergency Equipment Checklist to include all emergency items.
16. The facility needs to ensure that nurses check each piece of emergency equipment daily to ensure it is in good working order.
17. The facility needs to ensure nurses responsible for checking emergence equipment be re-trained so they can demonstrate competency in checking and operating all emergency equipment.
18. The facility needs to cross-walk the recently developed QA Medical POI Audit Tool with the SA and HCG to ensure that all areas required for compliance are addressed. The tool also needs to address quality of care provided by clinical disciplines and make recommendations for corrective action. The QA department needs to analyze, track and trend clinical performance data to identify areas of practice to ensure non-compliant practices demonstrates improvements.
19. As nursing develops and implements additional monitoring tools and generates additional clinical data, the Nursing Staff Meeting minutes need to include significant findings from these tools making it a succinct document. The nursing staff needs to develop and implement a system to analyze, track, and trend data that identifies areas where nursing practices needs improvement.

20. The facility needs to review their Mock Emergency Drills Procedure to ensure they are operating on the most recent revision and that the policy is compliant with generally accepted professional standards of care.
21. The facility needs to review and revise the current policy/procedure for conducting Medical Emergency Drills. It only includes the use of three scenarios, e.g., respiratory distress, cardiac arrest, and foreign body airway obstructions. These scenarios need to be expanded to include other scenarios that would warrant the demonstration of emergency procedures.
22. The facility needs have an Emergency Management Committee to review, analyze, track, and trend drill performance. A policy and procedure should be developed and implemented outlining the levels of committee review for Medical Emergency Drills, actual Code Blues and emergency procedures. A system should be developed and implemented to ensure that Medical Emergency Drills and actual Code Blues are critically analyzed, and plans of correction developed and implemented to address problematic issues.
23. The Mock Medical Emergency Drill Procedures should be changed to specifically state that physicians are required to participate in Mock Emergency Drills. The Mock Emergency Drill Sheets need to indicate whether or not physicians participated in the drill.
24. The facility needs to develop and implement a monitoring system requiring nurses to demonstrate the use of emergency equipment while ensuring that it is in good working condition.
25. The facility needs to review training records and ensure employees delinquent in CPR and Emergency Response Training are brought up-to-date.
26. The facility needs develop and implement a scheduling and tracking system to ensure that health related appointments were scheduled as recommended, missed and/or refused appointments were rescheduled, and appointments were tracked through to completion.
27. The facility needs to ensure that all facility staff receive and maintain infection control training according to infection control policies.
28. The facility needs to develop and implement formalized system in place to routinely analyze, track and trend data, and to develop and implement plans to correct problematic areas related to infection control measures.
29. The facility needs to ensure that corrective actions related to deficiencies in the Environmental Surveillance areas are carried out as recommended.
30. The nurses should receive competency-based training in Physical and Nutritional Management, particularly as related to Mealtime Challenges.
31. The nursing staff needs to include in their quarterly and annual assessments information from comment sections that describes clinical outcomes, e.g., whether the individuals' health status were progressing, maintaining or regressing, strategies that are working or not working, and to recommend changes, if indicated, in strategies, support and/or services.
32. The nursing department needs to develop and implement a monitoring system to ensure that NCPs and/or HMPs meet individuals' total health care needs, interventions are appropriate, implemented, and their effectiveness is evaluated.
33. The Health Risk Assessment Tool needs to be evaluated by the appropriate state and/or facility staff for clear criteria for determining risk to eliminate subjectivity, and to ensure that the tool meets accepted professional standards of care.
34. The facility staff responsible for creating/revising the PSP template needs to add the Nursing Section to the PSP template.
35. The facility needs to ensure that respective disciplines who plan individuals' care collaborate closely when developing discipline specific plans and PSPs to prevent inconsistencies and conflicting information in individuals' plans of care.
36. The facility needs to ensure that PSPs contain baseline data and detailed interventions.
37. The facility's nursing staff needs to participate with the PBST members in assessing, planning, implementing and evaluating programs and other activities that impact upon the individual's behavior.
38. The nursing department needs to thoroughly review all nursing policies and procedures to ensure they are in alignment with the SA and HCG. Policies and procedures that are no long operational needs to be purged from the Nursing Policy and Procedure Manual.
39. The nursing staff should work with the Physical and Nutritional Management staff to identify individuals that might be at risk for involuntary biting into a plastic spoon while receiving medication. For these individuals the Facility should consider use of hard plastic spoons for their administration of medication, like a "mother's care spoon".
40. The facility needs to update individuals' pictures to ensure they are correctly identified when receiving their medications.
41. The facility needs to discontinue the list used for individuals requiring alternate texture, consistency, oral presentation techniques, adaptive equipment, and/or positioning and replace it by including this information in their MARs, along with a copy of their PNMP.

42. Nursing SOPs NR100-59 through 74, Medication Administration: Rules/responsibilities, Date Established: August, 1987, Reviewed/Revised: December, 2007, Next Review/Revision: Date: December, 2008 and SOP NR100-60, Date Established: August, 1987, Reviewed/Revised December, 2007, Next Review/Revision Date: December, 2008 were not reviewed or revised for over two years. Nursing needs to be reviewed and revised to ensure that current professional standards of practice are followed and that they are in alignment with the SA and HCG.

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/STHCS Pharmacy Department, Medication Error Policy, Date Established: September, 2001, Reviewed/Revised: December 2007 2. Nursing Manual, SOP NR 100-66, Medication Error Policy, Date Established: September, 1998, Reviewed/Revised: December 2007, Next Review/Revision Date: December, 2008 3. RGSC/STHCS' Pharmacy Department Policy and Procedure Manual, Reviewed/Revised: March, 2009, Next Review/Revision Date: March 2010 4. RGSC Medication Error by Process Node, 9/08 through 9/09 – Graph 5. RGSC Medication Error Reports Filed by Med Investigations by month, 8/08 through 9/09 – Graph 6. RGSC Med Errors by Category FY09 – Graph 7. RGSC Pharmacy Audit Report, June 15 and 16, 2009, Submitted By, Ann L. Richards, Pharm. D. 8. RGSC Medication Management Meeting Minutes, 7/30/09, 8/24/09, 10/27/09, 11/23/09 9. RGSC Pharmacy and Therapeutic Sub-Committee Meeting (MR Minutes), 9/23/09 10. RGSC/STHCS Medication Management Processes Annual Evaluation FY09 11. RGSC Medication Error Event Reports, 02/04/09 for Medication Errors Reported 10/08/09 through 01/15/09 12. RGSC Medication Administration Record Audit Tool, started 11/2009 13. Record review of individuals #47, #108, #51, #39, #8, and #101 **Records Reviewed:** Partial Records Reviewed: Individuals #47, #108, #51, #39, #8, and #101 **People Interviewed:** 1. Yolanda Gonzalez, RN, Chief Executive Nurse 2. Marcy Valdez, RN, Nurse Manager 3. Jessica Juarez, RN, Quality Assurance Nurse 4. Anne Ikponmwonda, Pharmacy Director **Meeting Attended/Observations:** 1. Medication Administration Pass Observations in buildings 501 and 502
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The Pharmacy provides service from 8:00 a.m. to 5:00 p.m. Monday through Friday and has Pharmacist on-

	call provisions for services at other times. Although it was reported that the pharmacist conducts reviews of each individual's medication regimen, and when clinically indicated makes recommendations to the prescribing health care provider, documented evidence of such communication was not noted in the limited record review of individuals. Therefore, it could not be determined if the pharmacist identified no problems or if the documentation was not readily available for review. Quarterly Drug reviews were conducted according to policy. When indicated, recommendations were sent to the prescribing physician to accept or reject. No system was in place to track whether the recommendations were accepted or rejected or whether recommendations were implemented. Adverse Drug Reactions (ADR) and medication variances are reported and acted upon, as necessary, by the Pharmacy and Therapeutic Sub-Committee RGSC's nursing staff completed the DISCUS every three months and MOSES every six months. The assessments of these two items were not summarized on the Nursing Annual and/or Quarterly Assessments indicating individuals' side effects related to psychoactive medications. The facility nurses did not participate in the quarterly Personal Behavior Support Team (PBST) reviews to collaborate with other PBST members in assessing, planning, implementing and evaluating programs and other activities that impact upon the individual's behavior. The nurses did not develop a NCP and/or HMP with individualized goals and interventions to meet the individual's needs. The HMP needs include interventions for specific side effect monitoring by the staff and to reference behavioral interventions outlined in the PBSP. The Medication Administration Records (MARs) did not include any per necessary (PRN) medications. The staff nurses reported that the facility does not use standing PRN orders even for management of status epilepticus. If PRN medications were needed the physician was called for an order. After reviewing the facility's Medication Error Policy, it was discovered that the facility has two different operating policies/procedures. The policies and procedures contain similar but different information. This causes staff confusion and possible lack of compliance with the SA and HCG. RGSC's medication error data were combined with STHCS. Therefore, it was not possible to discriminate between the two facilities' data. The only raw data were represented in the form of graphs and numbers related to various medication error classifications of categories. The report did not include any clinical analysis of trends or needed interventions for addressing the prevention of medication errors. All reported medications errors, except one, were reported as having been found through discovery. Six of the medication errors were discovered within the next day through chart audit. One medication error was not discovered for over two months and another error was not discovered for over one month. Both of these medication errors were discovered through chart audit. Only one medication error was reported as

	observed. Most of the medication errors that were reported as documentation errors indicated that the nurses' initials were missing. It is questionable as to how blanks found on the MAR the next day or months later could be considered documentation errors and not omissions.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	RGSC' Pharmacy provides services to individuals within the Center's Mental Health and Mental Retardation Units from 8:00 a.m. to 5:00 p.m., Monday through Friday with the provisions for after hour's services (Pharmacist-on-Call). The Pharmacy is staffed with a Pharmacy Director, Pharmacist II, Pharmacist Consultant, two Certified Pharmacy Technicians II, one certified Pharmacy Technician I, and an Order Entry Clerk II. The Pharmacy Director reported that the pharmacist conducts reviews of each individual's medication regimen, and when clinically indicated makes 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 risk and associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with facility policy or current drug literature. Documented evidence of such communication was not noted in the limited record review of individuals #47, #108, #51, #39, #8, and #101. Therefore, it could not be determined if the pharmacist identified no problems or if the documentation was not readily available for review. This issue will be followed up on future tours.	
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.	Review of Individuals #47, #108, #51, #39, #8, and #101 indicated Quarterly Drug reviews were conducted according to policy. When indicated, recommendations were sent to the prescribing physician to accept or reject. There were no instances noted in review of the Quarterly Drug Reviews for the individuals above were the physicians rejected the pharmacy's recommendations. According to the Pharmacy Director, once recommendations were sent to the physicians, there was no tracking system by the pharmacy to ensure that the physician carried out the recommendations. A record of drug regimen reviews were maintained in a file in the office of the Pharmacy Director and/or subject to outside inspection (e.g., ICF/MR surveyors) or review by authorized persons. Quarterly Drug Regimens will be further reviewed on the next tour. The pharmacy needs to develop and implement a tracking system to determine whether or not pharmacy recommendations were accepted or rejected so that remedial action can be taken if necessary.	
N3	Commencing within six months of the Effective Date hereof and with	According to the Pharmacy Director, drug regimen reviews were conducted monthly and quarterly as well as when a new medication was order or upon a new admission.	

#	Provision	Assessment of Status	Compliance
	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.	Monitoring also included the use of "Stat" (emergency) medications, chemical restraints, benzodiazepines, anticholinergics, and polypharmacy. Of the records reviewed there were no significant contraindications noted. This was evident in record reviews of individuals #47, #108, #51, #39, #8, and #101. This issue will continue to be reviewed on the next tour.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Refer to N 2	
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.	RGSC's nursing staff completed the DISCUS every three months and MOSES every six month. The assessments of these two items were not summarized on the Nursing Annual and/or Quarterly Assessments indicating individuals' side effects related to to psychoactive medications. The facility nurses did not participate in the quarterly PBST reviews to collaborate with other PBST members in assessing, planning, implementing and evaluating programs and other activities that impact upon the individual's behavior. The nurses did not develop a NCP and/or (HMP) with individualized goals and interventions to meet the individual's needs. The HMP needs include interventions for specific side effect monitoring by the staff and to reference behavioral interventions outlined in the Behavior Plan.	

#	Provision	Assessment of Status	Compliance
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	Adverse Drug Reactions (ADR) and medication variances are reported and acted upon, as necessary, by the Pharmacy and Therapeutics Sub-Committee as evidenced in the 9/23/09, Pharmacy and Therapeutics Sub-Committee Meeting minutes who reported two ADRs in June, two in July, and two in August. No remedial action was recommended by the Committee. In addition, of the total 2,781 prescriptions, 296 needed clarification. This resulted in <.04% variance; no recommendations were made for remedial action.	
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.	A Drug Utilization Evaluation (DUE) was completed annually. This was validated through review of the 9/23/09, Pharmacy and Therapeutic Sub-Committee Meeting minutes. There were no recommendations made regarding the DUE, except to continue to monitor. Although Quarterly Drug Regimen Reviews and Annual DUE Reviews were conducted, the Drug Regimen Review Policy and Procedure failed to describe procedures for conducting, reviewing, and taking remedial action. The pharmacy needs to review their policy to describe procedures for these functions.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	After reviewing the facility's Medication Error Policy, it was discovered that the facility has two different operating policies/procedures, e.g., Nursing Manual, SOP NR 100-66, Medication Error Policy, Date Established: September, 1998, Reviewed/Revised: December 2007, Next Review/Revision Date: December, 2008 and Pharmacy Department, SOP PH100-16-01-09, Medication Error Policy, Date Established: September, 2001, Reviewed/Revised: December, 2007, Next Review/Revision Date: December, 2008. The policies and procedures contain similar but different information. This causes staff confusion and compliance with the SA and HCG. Neither of the two medication error policies and procedures have been updated since 2007. It is important to ensure operating policies and procedures comply with current professional standards of care and the SA and HCG. The facility's Medication Errors Policies and Procedures were based on the National Council for Medication Error Reporting and Prevention guidelines. Medication errors are classified by the Medication Error Categories/Severity Index; used to standardize the level of patient impact caused by medication errors. These categories classify an error according to severity of outcome by considering factors such as whether the error	

#	Provision	Assessment of Status	Compliance
		reached the individual, if the individual was harmed and, if so, to what degree. Categories range from lesser to greater severity, e.g., Categories A through I. Review of the facility's Medication Error Event Report, dated February 4, 2010, indicated that a total of nine medications errors were reported. Reported medication errors are described below: • Seven of the errors were classified as category A (Neither error or harm occurred. The circumstances or events only had the *potential* to cause an error.). According to the explanation found upon investigation: Three were due to documentation errors, two were due to transcription errors, one was due to a communication error, and one was identified as other. • Two errors were classified as category C (An actual error occurred. The error *reached* the individual. The individual was *not* harmed by the error.). According to the explanation found upon investigation: Both errors were due to administration errors. All reported medications errors, except one, were reported as having been found through discovery. Six of the medication errors were discovered within the next day through chart audit. One medication error was not discovered for over two months and another error was not discovered for over one month. Both of these medication errors were discovered through chart audit. Only one medication error was reported as observed. Most of the medication errors that were reported as documentation errors indicated that the nurses' initials were missing. It is questionable as to how blanks found on the MAR the next day or months later could be considered documentation errors and not omissions. The golden rule is "if it was not documented it was not done." The medication errors reported and investigated were determined not to have caused harm. It was also questionable as to how it was determined whether or not the medication errors had caused an impact or harm to individuals health status when they were not discovered until a day or months later. The large number of medications administered at the facility as compared to the low number of reported medication errors indicates the possibility of under-reporting and lack of self-reporting of medication errors. These concerns will be further explored at the next compliance tour. Reports of medication errors were sent to the CEN for review and further reviewed at Medication Management Meetings. Review of the Medication Management Meeting minutes, July through November, 2009, indicated that discussions regarding medication errors centered on issues relating to how data was entered into the Clinical Work Station system as opposed to clinical issues related to corrective actions that had been taken to prevent or reduce the incidents of medication errors. A Medication Administration Record Audit Tool was implemented in November, 2009. The nurse manager was required to review at least three individuals' MARs per week for	

#	Provision	Assessment of Status	Compliance
		a total of three reviews for the campus per week. Results of weekly MAR audit were not available for review, nor were quarterly medication administration observations sheets. Considering the number of medications administered at the facility, this level of monitoring is inadequate to make a significant improvement in identifying medication errors. The nursing department needs to increase the frequency of MAR audits and medication observation passes to identify medications errors promptly and take appropriate interventions to protect individuals' health and safety. This issue will be further reviewed at the next compliance tour. Review of the facility's medication error data, 2008 through 2009, reported from the Clinical Workstation Station, found RGSC's data were combined with STHCS. Therefore, it was not possible to discriminate between the two facilities' data. The only raw data were represented in the form of graphs and numbers related to various medication error classifications of categories. The report did not include any clinical analysis of trends or needed interventions for addressing the prevention of medication errors.	

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

1. The pharmacy needs to develop and implement a tracking system to determine whether or not pharmacy recommendations were accepted or rejected so that remedial action can be taken if necessary.
2. The facility's pharmacy needs to review/revise their Drug Regimen Review Policy and Procedure and describe procedures for conducting, reviewing, and taking remedial action.
3. The facility's nursing staff needs to summarize individuals' therapeutic responses to psychoactive medications on their Nursing Quarterly and Annual Assessments.
4. The facility needs to consolidate the two existing Medication Error Policies and Procedures into one succinct document.
5. The facility needs to update their Medication Error Policies and Procedures to ensure operating policies and procedures are compliant with professional standards of care and the SA and HCG.
6. The facility's nursing department needs to develop and implement a system to analyze, track and trend clinical data for medication errors. This data needs to be used to develop interventions to prevent or reduce medication errors. Data findings need to be included in the Nursing Monthly Staff and Medication Management meetings
7. The facility's nursing department needs to increase the frequency of MAR audits and medication administration observation passes. Findings from audit and medication administration observation passes should be included in a system to analyze, track and trend clinical data relating to medication errors.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken: **Documents Reviewed:** 1. Comprehensive record reviews of four individuals (Individual #19, Individual #51, Individual #47, and Individual #101) 2. Partial record reviews of 12 individuals (Individual #94, Individual #10, Individual #96, Individual #60, Individual #15, Individual #140, Individual #79, Individual #113, Individual #55, Individual #85, Individual #36 and Individual #27. 3. Review of requested tour documents including but not limited to: a. Risk lists pertaining to aspiration, choking, skin breakdown, falls, weight loss and weight gain b. Occupational and Physical Therapy reports c. Nutritional Management Meeting minutes d. PNM monitoring tools e. Dining Plans f. PNM policies and processes 4. Health Care Guidelines Section VI-Nutritional Management Planning and Section VIII-Physical Management **People Interviewed:** 1. Sara Smalley OTR, Habilitation Therapies Coordinator and Occupational Therapist 2. Yolanda Gonzales RN, Chief Executive Nurse 3. Betty Perez, PNMP Technician 4. Marcy Valdez RN, RN manager 5. Myrna Wolf, QMRP Coordinator 6. Alondra Machado, Quality Administrator 7. Erlinda DeVera MD, Physician 8. 5 PNAs at 501(2 am and 3 pm) and 4 PNAs at 502 (1 am and 3 pm) **Meetings Attended/Observations:** 1. Observations of 501 and 502 living areas and dining rooms (am and pm) 2. Observed general oral care, positioning, and medication administration on 501 and 502 3. Attended 501 morning unit meeting, HST quarterly, PNMP meeting and 502 shift change
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor Assessment: Individuals who are at a "high risk" are not being identified and therefore may not be receiving the care and treatment required to prevent future illness. While most individuals have a PNMP, the PNMPs are not considered to be appropriate due to oral hygiene, medication administration, behavioral information, and

	signs and symptoms associated with aspiration or decline not being included as part of the document. Additionally, the assessment process involved in the development of the PNMPs is flawed secondary to little input being provided by therapy regarding positioning for GERD management, oral hygiene techniques, water safety and presentation of medications. Staff was not observed referring to dining cards or PNMPs. Individuals are provided with care according to the PNMPs at best sporadically. Multiple situations occurred in which individuals were eating or positioned in a manner that may result in an increased risk of choking and or aspiration. If there is a change in care, all plans relevant to that individual are not always updated and trained in an efficient manner. Overall, there needs to be more of a proactive, cooperative, collaborative, systemic approach to address physical and nutritional support issues.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by 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	Although RGSC has a team that meets as part of the HST, the team's scope is too limited and narrow; it does not proactively and comprehensively address the wide ranging needs of the individuals. The team consists of an occupational therapist, physical therapist, dietitian, QMRP, nurse, and physician; however, the team focuses primarily as a medication and medical health status review and does not address the individualized physical needs and concerns of the individuals. Additionally, the individuals discussed appear to be based on schedule and not recent health events. A PNMP team does exist and meets monthly consisting of the OT, RN, QMRP, RD, and various other professionals and staff. The focus of this meeting is primarily on the physical aspects of physical and nutritional management. Upon review of past team minutes, the meeting was chaired by the PNMP technician, who is not a therapist and therefore may not have the expertise to chair such a team; by report of the Facility, the OT began chairing the meetings in May, 2009 but this was not reflected in minutes until December, 2009. The team minutes revealed multiple occurrences in which issues were noted to be ongoing but there was no follow up noted during the next meeting. For example: • On 5/18/09; Individual #79 was to be followed up the next month due to weight loss;, however, there was no documentation of follow up during the 6/15/09 meeting. Per review and observation, there is not active involvement by the speech pathologist in the monthly PNMP or HST meetings as the Speech Therapist is rarely on campus and when present, is only available on Sundays. In addition to the absence of a therapist,	

#	Provision	Assessment of Status	Compliance
	input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	there was no active collaboration or sharing of information noted. There is no documentation that team members had participated in any form of specialized training regarding physical and nutritional management. RGSC does have physical and nutritional management plans (PNMP) in place for all individuals identified as having PNM needs however the PNMP is lacking information concerning oral care strategies and medication administration. Also, the PNMPs are often vague and do not provide consistent information regarding status and/or needs. Additionally, the PNMP is not integrated into the individual's Personal Support Plan (PSP) other than being referenced. Little to no information is provided regarding how the PNM supports improve the individual's life and how interventions are integrated into the individual's daily schedule. Nursing Care Plans are inconsistent and often contain conflicting information as evidenced by the aspiration nursing care plan for Individual #51 stating chopped foods while the cerebral palsy nursing care states he receives pureed foods. PNMPs are also inconsistent with other health plans as evidenced by the PNMP for individual# 51 stating he should remain upright one hour after meals when the nursing care plan states 30-45 minutes. Issues were found regarding the transfer and timely implementation of recommendations when an individual returns home from the hospital. PNMPs, Nursing Care plans, and risk screenings are not always revised in a timely manner in response to a change in status. For example: • Individual #47 returned from the hospital on 11/24/09 with a g-tube. The PNMP was revised on 11/24/09, but the Special Staffing Summary section was dated "12-01-09" and the Team Discussion section was blank. The PNMP was revised again 12/29/09, with the Special Staffing Summary dated "12-30-09" and the Team Discussion section blank. • Individual #47 was placed on enteral nutrition on 11/24/09; however, the nursing care plan 12/17/09 states that he still receives food by mouth. The care plan was not revised until 2/22/10. • Risk screenings for Individual #47 were not updated until 1/4/10 although there was a significant change in status at the end of November 2009. • Physician's order for Individual #47 to remain at 45 degrees when in bed at all times; however, this order was not carried over and listed in his nursing plan or PNMP.	
O2	Commencing within six months of	Many RGSC individuals have medical conditions that seriously complicate the swallowing	

#	Provision	Assessment of Status	Compliance
	the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	and digestion of their food and beverages as well as increase their difficulty in being able to safely manage their oral secretions. Aspiration Pneumonia is often a preventable condition that results from the accumulation of foreign materials (usually food, liquid, or reflux) in the lungs. RGSC lists only 2 individuals as at "high risk" yet several individuals who do not appear on the Facility's high risk list were hospitalized for aspiration or choking related events or identified through videofluoroscopy or by team members as having symptoms drastically increasing the risk of aspiration. Based upon observation, there were a significant number of individuals who were observed to be at "high risk" but were listed as being at "low risk" according to their screening forms. Currently RGSC's aspiration and choking risk lists has 59 listed as at "low risk", 3 listed as at "medium risk" and 2 at "high risk." Thorough review of the "At Risk" policy revealed multiple issues. One was that the center was incorrectly following the policy as RGSC was placing the majority of their individuals as being at "low risk" when they should have been placed as at "medium risk." Second, the policy as written is flawed in its ability to identify those who are at a "high risk" of physical and nutritional decline. In its current state, the policy identifies individuals as being at "High Risk" if they are having an acute issue, "Medium Risk" if they require ongoing supports (i.e., a PNMP), and "Low Risk" if they do not require supports. Following the policy as written would result in RGSC having the majority of its population listed as "Medium Risk" since most of the individuals have PNMPs. This type of risk classification system is not functional or useful to the clinicians or the individuals living at RGSC. Examples that the current system is not accurately identifying those who are at risk include: • Individual #94 was identified as having severe pocketing and severe oral residue and required to be on a pureed diet however was listed as being at a "Low Risk" of aspiration/choking • Individual #10 was identified as having moderate to severe pharyngeal dysphagia and had a hospital visit on 1/21/10 due to showing signs of aspiration however was listed as being at a "Low risk" of aspiration/choking • Individual #51 was diagnosed with aspiration on 4/28/09 however was listed as being at a "Low risk" of aspiration/choking Constipation is another preventable condition given appropriate care. As with other conditions, RGSC is failing to identify all those individuals truly at risk and this hampers or eliminates the possibility of providing proper preventative services and supports. For example:	

#	Provision	Assessment of Status	Compliance
		• Individual #96 and Individual #60 received medications for constipation but are listed as being at a "Low Risk" of constipation. As with Aspiration and Constipation; falls are not being adequately categorized as it relates to risk. For example: • Individual #15 had falls occurring on 11/30/09 and 1/18/10 but was listed as being at a "Low Risk" of injury. • Individual #140 had falls occurring on 11-17-0, 11-21-09, 11-23-09, 12-14-09, 12-21-09, and 12-29-09. The Health Support Team reviewed the case and again was listed as being at a "Low Risk" of injury. In addition to the issue noted above, there was no criterion that guides the team in determining level of risk. The level of risk is highly subjective. Another issue was that there was no screening that focuses on pneumonia risk. Aspiration/Choking is screened and this screening does contain some components of pneumonia risk identification but the issues leading to an increased risk of pneumonia and choking often varies, thus making a single "catch all" screening very difficult to be highly accurate. Individuals who are required to undergo videofluoroscopies are not followed by the SLP or OT to the study. This was reported not to happen due to the hospital not allowing an outside therapist to participate in the study. Per report by the Habilitation Therapies Coordinator, not having the appropriate follow through results in a breakdown of the continuum of care and miscommunication between the hospital and RGSDC There was not a clear process in place in which the PNMP team is notified when a sign or symptom associated with aspiration occurs. Currently, notification relies on PNAs determining an issue is severe enough to contact nursing, then nursing determining an issue is severe enough to contact the physician and make a referral. This results in clinical judgments regarding PNM being made by individuals who are not clinicians and the likelihood that many signs and symptoms that are not overt are be missed. This is a more reactive than proactive approach that may result in serious incidents occurring that might have been prevented with earlier intervention. During several meals on 501 and 502, coughing was observed but no interventions were provided and no referrals were made in response to these issues.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication	PNMPs have been developed for individuals residing at RGSC; however, the PNMPs are inadequate as the risks associated with oral hygiene and oral medication are not addressed in the current format. Also, plans are vague and do not provide consistent comprehensive information. For example: • The PNMPs for Individual #55 and Individual #27 list N/A under mobility rather than stating they ambulate independently. The same issue is noted under	

#	Provision	Assessment of Status	Compliance
	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.	feeding as well as equipment As mentioned in provision O.1, PNMPs were not consistent and updated in a timely manner in response to a change in status. Currently, therapy (OT, PT, and SLP) has no role in developing oral hygiene plans or input into the method in which oral medication is provided. Oral management as well as positioning of person and staff associated with these two activities is essential to minimizing the risk of aspiration. Oral hygiene plans are currently developed only by nursing and the method in which medications are provided are determined solely by the physician. The MARs did not contain the individual's PNMP, nor were special needs for alternate texture, consistency, oral presentation techniques, adaptive equipment, and/or positioning listed on the MARs. Therapy should play an integral role in determining the methods to be utilized during these activities as well as determining head of bed elevation for individuals who receive enteral nutrition or have a diagnosis of GERD. In its current form, this information is provided by only the physician and is based mostly on standard protocols and was not individualized. PT/OT should play a vital role in determining these issues as they are the ones who are most familiar with the individuals' positioning and skeletal structure.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	Based upon observations, it was noted that implementation of the dining cards and PNMPs are sporadic at best. For example: • Individual #51 is required to remain upright 60 minutes post meal but was observed lying flat in his bed immediately following the meal. • Individual #36 requires verbal cues to eat slowly and to take small bites however she was observed walking around the room before returning to her plate where she proceeded to stand and eat at a fast and unsafe rate. • Individual #85 should be cued by staff to alternate liquids and solids, however this was not provided. Please refer to provision M.5 for additional information regarding staff knowledge and implementation of PNM supports. Based upon multiple discussions and observations with 501 and 502 direct care staff, knowledge regarding physical and nutritional management and supports were not evident. PNAs were unaware of the individuals' level of risk or the rationale behind the recommendations listed on the PNMPs and dining cards and how not following these recommendations would increase the level of risk.	

#	Provision	Assessment of Status	Compliance
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.	As mentioned in provision O.4, PNAs were not able to verbalize rationale for PNM interventions. Per document review and interview, all PNAs participate in a foundational class during orientation; however, this course was not renewed or recertified on an annual basis. All of the PNAs interviewed mentioned that it was difficult remembering all the information. Additionally, the training primarily focuses on mealtime issues and does not fully address the concept of physical and nutritional management. Person-specific training was provided to staff who routinely work at a specific home; however, there was no process in place to provide this additional training should a home have to utilize floating or pull direct care staff from another home. It is essential that PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff who have successfully completed competency-based training specific to the individual.	
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.	Monitoring was conducted by professionals, PNMP technician, and senior PNAs; however, there was not a clear process in place that outlines the frequency in which individuals will be monitored (i.e., high risk vs. low risk) or the response if a deficiency was noted. Additionally, staff on 501 who conducted a monitor stated they had received little to no additional training on how to complete the form, and what signs or symptoms should be monitored. This was evident by a mealtime the monitoring team observed as well as a senior PNA. The monitoring team found multiple deficiencies associated with the mealtime but the senior PNA found only one. In order to be an effective monitor, one must have the skills necessary to identify potential early warning signs associated with physical and nutritional decline. Example of observations that were not noted by RGSC monitor include: • Individual #19 positioned poorly during the meal • Individual #94 coughing throughout the meal with no intervention or reporting • Individual #113 coughing throughout the meal with no intervention or reporting In addition to the inconsistencies, a process does not exist that includes validation checks to ensure accuracy of monitors. There is also not a process in place that tracks the data from the forms so that it may be analyzed and used to drive future services.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two	The current monitoring system focuses primarily on whether or not equipment is available and staff are implementing the strategies as listed in the PNMP and dining plan. The effectiveness of the plan was not clearly monitored. The determination of whether a	

#	Provision	Assessment of Status	Compliance
	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.	plan is effective or not requires clinical decision making and therefore should only be completed by individuals who have expanded experience with physical and nutritional issues. Examples of individuals completing such monitors include the nurses, QMRPs, Speech Therapists, Dietitians, Occupational Therapist, PNMP technicians, and Psychologists. Findings of the current monitoring forms are filed with the Incident Management Coordinator but there was not a clear system in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with physical and nutritional risk. The PNM team does meet monthly to discuss health issues related to PNM but response to indicators identified by monitoring did not appear to be a focus of conversation nor did the development of the PNM system.	
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.	As of 3/1/2010, there was only one individual receiving enteral nutrition. The change of status was relatively recent; therefore, there has not been a need to reevaluate the continued necessity of enteral nutrition as of the review date. The Habilitation Coordinator and Chief Executive Nurse stated a process does not exist. Individual #47 was observed receiving enteral nutrition. The nursing staff was observed following correct procedure for administering bolus enteral feeding via G-tube. Refer to provision M.3 for additional information.	

Recommendations:

1. RGSC should review their entire PNM system to ensure that the PNM team is a therapy driven collaborative team that focuses on proactive preventative care.

2. Individuals who are at a high risk are not being identified due to the criteria set forth by the "At Risk" policy as well as inadequate follow through of said policy. This is an issue both of definitions and procedures in the statewide policy and of RGSC not following that policy accurately in identifying risk levels for individuals. Therefore, RGSC in coordination with other state centers and the state of Texas should revisit the policy and redesign so that is identifies those who are at risk. Additionally, the level of risk should be openly shared with staff and used to help drive and shape future services.

3. The PNMP team should investigate ways to further integrate their meeting into the HST meeting. Additionally, the PNMP team should be chaired by

someone who has the clinical experience regarding PNM.

4. Assessments should be reviewed and revised so that all aspects of physical and nutritional management are addressed. This includes assessing an individual's positioning and swallowing capabilities during oral care and medication administration and head of bed positioning for improved GERD management and stomach emptying. RGSC should also focus on improving the use of measurable terminology and consistency between assessments and clinicians. It is important to remember that PNM is not just related to OT, PT, and SLP. Nursing as well as Dental staff participation is vital; all members of the team should assist in the development and monitoring of the PNMP.

5. PNMPs should be revised to contain the strategies identified via the assessments and eliminate vague terminology with regards to the listed strategies in an effort to increase consistency of implementation by staff. Included in the PNMP and PNM process should be oral care, medication administration and signs and symptoms associated with aspiration that mandates nursing referral, assessment (vitals, lung sounds, and oxygen saturation) and PNMP referral. Training as well as reporting and recording of all incidents should be part of developing this process. As it is now, too many issues are going unnoticed and under assessed. Dining Plans that are functional and helpful to the staff should be developed as well to help increase implementation. All plans should be readily available at the point of service (i.e., MARS for Nurses)

6. A process should be developed that provides clear guidelines regarding the timeliness in which new interventions or change in status information is integrated into all support plans. Currently, this process is informal which results in inconsistent integration.

7. Steps should be taken to ensure active collaboration between RGSC therapists and the therapists at Valley Baptist Hospital regarding swallow studies. It is imperative that RGSC therapists be allowed to be present and participate in these tests so that functional treatment can be established upon return.

8. A training system should be considered that ensures all staff are regularly trained on all aspects of physical and nutritional management. The training curriculum needs to be expanded with specific learning objectives and competencies to provided foundational knowledge and skills related to: mealtime position and alignment, diet texture and consistency, presentation techniques to enhance nutritional intake and hydration, care and use of adaptive equipment, aspiration and choking precautions, purpose of a swallow study, strategies to support independence during PNM activities, presentation and alignment to support safety during oral care, bathing, and medication administration. This should include orientation training as well as regular updates. Care should also be taken to ensure that all staff are provided with individualized competency based training prior to working with an individual who is considered to be at an increased risk.

9. A monitoring system should be implemented that focuses on plan effectiveness rather than just presence and implementation. All staff conducting the monitoring for plan effectiveness should have the clinical knowledge to make such determinations and those monitoring for implementation and presence should have additional training as well to ensure consistency and accuracy. Examples of individuals completing such monitors include the nurses, QMRPs, Speech Therapists, Dietitians, Occupational Therapist, PNMP technicians, and Psychologists. The system should be data driven to allow proper analysis and tracking of trends.

10. Comprehensive evaluation should be utilized to determine their feasibility of returning to oral intake and to allow for comparison of swallow function from year to year. Identified in these evaluations should also be strategies that have been developed to transition an individual to oral intake, if appropriate. The need for evaluations and the process for providing these evaluations should be clearly defined in policy.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken:** **Documents Reviewed:** 1. Comprehensive record reviews of four individuals (Individual #19, Individual #51, Individual #47, and Individual #101) 2. Partial record reviews of 12 individuals (Individual #94, Individual #10, Individual #96, Individual #60, Individual #15, Individual #140, Individual #79, Individual #113, Individual #55, Individual #85, Individual #36 and Individual #27. 3. Review of requested tour documents a. Occupational and Physical Therapy assessments b. Occupational and Physical Therapy polices and processes c. List of individuals with skin breakdown and/or falls over the past 12 months 4. Health Care Guidelines Section VI-Nutritional Management Planning and Section VIII-Physical Management **People Interviewed:** 1. Sara Smalley OTR, Habilitation Therapies Coordinator and Occupational Therapist 2. Betty Perez, PNMP Technician 3. Myrna Wolf, QMRP Coordinator 4. Alondra Machado, Quality Administrator 5. 5 PNAs at 501(2 am and 3 pm) and 4 PNAs at 502 1 am and 3 pm) **Meetings Attended/Observations:** 1. Observations of 501 and 502 living areas and dining rooms (am and pm) 2. Observed general oral care, positioning, and medication administration on 501 and 502 3. Attended 501 morning unit meeting, HST quarterly, PNMP meeting and 502 shift change
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor Assessment: Currently, RGSC has one full time Occupational Therapist and a part time Physical Therapist who provides an average of 10 hours per week. RGSC has listed a full time position but as of this review, the position has not been filled. Habilitation Therapies have and continue to provide assessments based on the frequency identified per policy; however, reassessments in response to incidents are lacking for the individuals living at RGSC. For example: • Individual #15 had falls on 11-19-09 and 12-27-09, but there is no evidence of follow up or reassessment by OT/PT • Individual # 85 had falls on 11-30-09 and 1-18-10, but there is no evidence of follow up or reassessment by OT/PT

	While the assessments contained information relevant to areas of functional mobility and adaptive positioning equipment, they were lacking in detail contained in HCG VII. Missing information includes behavioral issues and how they impact PNM, oral management and positioning during medication administration and oral hygiene as well as positioning for GERD management and stomach emptying. The rationale and justification behind a therapists' recommendation was also lacking in detail and did not provide a clear picture of how the interventions would benefit the individual. Individuals who have plans in place (positioning, alternative positioning, and/or mealtime) are not consistently provided with supports, and there is not an effective monitoring system in place that provides reliable data and tracking.

#	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.	All individuals at RGSC have been provided with assessments annually if receiving services and every 3 years if not receiving services; however, the assessments are lacking in detail as it relates to providing the justification of recommended interventions and how these interventions are meaningful to the individual and improve their overall level of functioning. The records are extremely disorganized and fragmented. Partial record reviews indicated the OT/PT assessment are located under the "staffing tab" in one record, the "adjunctive tab" in another record and per report, under the therapy tab in others. At times, the OT/PT assessment was able to be located however this was not consistent across the sample. The OT/PT assessments have been integrated into a single assessment; however, the assessments are not consistently completed in tandem and at times were only completed by the OT.	
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	While the PT/OT assessments have been completed, they are not adequately integrated into the PSP. Upon review of the PSP, the assessments are mentioned but are not integrated as part of the summary of the individual and do not clearly provide information regarding the individual's strengths and weaknesses and how the proposed interventions provided in the PT/OT assessment will benefit the individuals in living a more independent and functional life. Plans developed by the PT/OT assessments include positioning, dining cards, and	

#	Provision	Assessment of Status	Compliance
	days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	PNMPs. Vague terminology is present throughout these plans resulting in multiple interpretations of what is required for the individual. For example: • Individual #36 plan states "Encourage eating at a slow pace." Upon interview with multiple PNAS at 501, the monitoring team received multiple ways on how staff slow the individual's pace down instead of a single cohesive approach.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	PNAs were provided with initial training, but there is not a clear process for ensuring ongoing education. Refer to provision O.4 for details	
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	There was not a clear policy or process in place that clearly defined frequency or depth of the monitoring process, nor did it provide direction regarding its implementation and action steps to take should issues be noted. See also provision O.7.	

#	Provision	Assessment of Status	Compliance
	of these interventions.		

Recommendations:

1. The current assessment format needs to be reviewed to determine if it is sufficiently comprehensive to identify the needs of the individuals at RGSC. Special care should be given to the areas of oral care and medication administration as well to improving overall detail.

2. Habilitation Therapy information should be integrated into the PSP and not just merely referenced. Justifications for the interventions and how these interventions play a role in improving the quality of life as well as how they are integrated into other areas of living should be included.

3. The record should be reorganized so that all information related to Habilitation Therapy is included together under a single tab. Currently, the record is severely fragmented resulting in difficulty obtaining a clear picture of the individual. An option may be to expand the current PNMP tab to include Habilitation Therapies since these areas are all linked to physical and nutritional management.

4. A training system should be considered that ensures all staff are regularly trained.

5. A monitoring system should be implemented that focuses on plan effectiveness rather than just presence and implementation.

SECTION Q: Dental Services	
	Steps Taken: **Documents Reviewed:** 1. RGSC Mental Retardation Services Manual, SOP MR 300 19: Premedication for Medical and Dental Procedures, Date Established, November 2004, Revised January 2008 2. RGSC Mental Retardation Services Manual, SOP MR 400 07: Invasive Procedures, Date Established, June 2002, Reviewed February 2010 3. MR Resident Dental Visits reports, March 20, 2008 through January 15, 2010 for Individuals: #31, #55, #72, #27, #4, #48, #141, #93, #33, #63, #85, #139, #58, #149, #96, #91, #66, #140, #133, #86, #88, #23, #47, #126, #8, #121, #13, #108, #69, #118,#61, #26, #82, #62, #94, #2, #75, #79, #54, #74, #84, #98, #11, #60, #16, #39, #101, #1, #29, #67, #97, #107, #77, #116, #19, #122, #59, #87, #12, #76, #21, #113, and #5 4. Pre-sedation Report, March 20, 2008 through February 5, 2010 for Individuals: #31, #55, #72, #27, #4, #48, #141, #93, #33, #63, #85, #139, #58, #149, #96, #91, #66, #140, #133, #86, #88, #23, #47, #126, #8, #121, #13, #108, #69, #118,#61, #26, #82, #62, #94, #2, #75, #79, #54, #74, #84, #98, #11, #60, #16, #39, #101, #1, #29, #67, #97, #107, #77, #116, #19, #122, #59, #87, #12, #76, #21, #113, and #5 **People Interviewed:** 1. Dr Erlinda DeVera MD, MR Physician **Meetings Attended/Observations:**
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor Assessment: The facility does not provide onsite dental services. Dental services are provided through a privately contracted dentist. Obtaining dental services for individuals who reside at RGSC is challenging. RGSC's Mental Retardation Services Manual, Standard Operating Procedure, MR 300 19: Premedication for Medical and Dental Procedures, Date Established November 2004 has not been revised since January 2008. This policy fails to meet the requirements of the Settlement Agreement. The procedures in this policy require that an individual's information and documentation be made to an array of various forms as well as to unspecified forms. It also requires the review of information from unspecified documents. No where does it indicate the need for a centralized tracking system to inform the PST of the individual's dental condition or necessary dental supports and interventions. There was no centralized tracking system in place to ensure that dental appointments were kept, or appointments missed or refused were rescheduled in a timely manner. The reports reviewed indicated that there were numerous refusals of treatment. There are no systems in place to flag when routine annual appointments and follow-up visits are due. Since there was no centralized tracking system it was not possible to track refused and missed appointments.

	The records were disorganized and fragmented. The individuals' information may be documented in as many as four binders (i.e. Records) under multiple tabs, the Clinical Work Station, and in many various meeting minutes (i.e. Health Status Team Meeting Minutes, Personal Support Planning Meetings Minutes, Human Rights Committee Meeting Minutes, etc.). This causes the facility difficulty in providing integrated services for individuals. The facility does not prepare data summaries for use by the facility related to dental services and/or quality assurance/enhancements reports, including subsequent corrective action plans.

#	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.	Dental services were provided through a contract with a private offsite dentist as RGSL does not provide dental services at the facility. The dentist had the ability to provide general anesthesia when necessary. Dr. DeVera, facility MD, was responsible for coordinating dental services. She explained procuring dental services for individuals who live at RGSC was very challenging because individuals were uncooperative and often require pretreatment sedation and some may require general anesthetic. The dentist under contract only sees one to two individuals per month. Dr. DeVera stated that this was not adequate coverage to meet the needs of RGSL's population and that the facility was exploring additional dental services. Dr. DeVera also stated that a Dental Hygienist was recently contracted and provided training to the direct care staff on the use of suction toothbrushes. In addition, she stated that a full time Dental Hygienist was needed at the facility to assist with providing oral hygiene and training of direct care staff. As part of Annual and Quarterly Nursing Comprehensive Assessments, nurses were responsible for assessing oral hygiene needs and developing plans of care to meet identified needs. Often, this results in the necessity to train direct care staff. Nurses are not dental hygienists and need additional training by a Registered Dental Hygienist to assist them in identifying and assessing the individual's oral hygiene needs. A review of 58 individuals' MR Resident Dental Visits reports, generated from the Clinical Work Station (CWS) for the past six months was conducted (see above identification numbers for records reviewed). Of the records reviewed 52 had received one or more dental visits as recommended. Three individuals did not have services provided in the last six months because their scheduled annual visits were not due during the time period reviewed. The remaining three individuals did not receive dental services within the last six months even though they have chronic dental conditions. Individual #139's last reported dental visit was on 10/30/08 for possible caries and gingivitis for which the dentist recommended dental rehabilitation. Individual #2's last reported dental visit was on 08/14/08 for periodontal disease. Individual #84 who had a documented history	

#	Provision	Assessment of Status	Compliance
		of chronic gingivitis and caries last reported dental visit was on 12/04/08. According to generally accepted standards of care individuals with chronic dental conditions should have had follow-up services provided during the reporting period. It is important to point out the conflict between the number (52) of individuals listed on the MR Resident Dental Visits reports as having received one or more dental visits verses Dr. DeVera's statement that only 1 or 2 individuals are able to be seen monthly by the contract dentist. Monitor team will review this more closely at the first compliance visit. The Clinical Work Station, MR Resident Dental Visits report failed to report any information regarding the PSP Strategies, Visit Notes, or any other information from the facility. This report contained only information noted from the offsite dentist except for an indicator box noting whether Pre-Sedation PSP was recommended. The term pre-sedation is printed on the MR Resident Dental Visits reporting form. Therefore, this term was used in the report when describing information the reporting form as opposed to the accepted term "pre-treatment sedation," as use in other sections of the report. The review of the Pre-sedation Report indicated that 32 of the 58 individuals (55%) received pre-treatment sedation. The facility's reports failed to provide documentation regarding PSP strategies established to ensure that pre-treatment sedation is administered only when less restrictive interventions have failed or been deemed inappropriate. The documentation failed to indicate if approval from the Human Rights Committee was given and if there was Informed Consent from the legally authorized representative. The review found notes indicating that two individuals, #55 and #8, received general anesthesia, however, there were no pre/post treatment sedation nursing notes regarding the individuals' health status documented in the reports reviewed. Nurses need to work collaboratively with other relevant PST and HST members to ensure that effective monitoring systems are developed and implemented to monitor individuals who receive pre-treatment sedation for dental/medical treatment as well as for post- treatment sedation until the individual is fully recovered.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services;	The Settlement Agreement Section Q.2. Dental Services requires the facility to provide current dental records, tracking data, and assessments to inform the PST of the individual's dental condition and necessary dental supports and interventions. The Settlement Agreement also requires that the facility develop and implement policies and procedures to provide dental services and comprehensive and timely assessments of dental services to the PST. RGSC's Mental Retardation Services Manual, Standard Operating Procedure, MR 300 19:	

#	Provision	Assessment of Status	Compliance
	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.	Premedication for Medical and Dental Procedures, Date Established November 2004 has not been revised since January 2008. This policy fails to meet the requirements of the Settlement Agreement. The procedures in this policy require that an individual's information and documentation be made to an array of various forms as well as to unspecified forms. It also requires the review of information from unspecified documents. Nowhere does it indicate the need for a centralized tracking system to inform the PST of the individual's dental condition or necessary dental supports and interventions. RGSC's Mental Retardation Services Manual, Standard Operating Procedure MR 400 07: Invasive Procedures, Date Established, June 2002, Reviewed February 2010 fails to meet the Settlement Agreement. The purpose of this procedure was to establish a process to ensure appropriateness and medical efficacy for invasive medical and dental procedures. The procedure requires that the Consent for Invasive Medical/Dental Procedure be noted in the daily Nursing Report. The nurse responsible for obtaining the Consent for Invasive Medical/Dental Procedure should also document that the signed consent has been received and given to the QMRP in the Integrated Progress Notes so that it becomes a part of the legal record for the individual. There was no centralized tracking system in place to ensure that dental appointments were kept, or appointments missed or refused were rescheduled in a timely manner. The reports reviewed indicated that there were numerous refusals of treatment. There were no systems in place to flag when routine annual appointments and follow-up visits are due. Since there was no centralized tracking system it was not possible to track refused and missed appointments. The nurses were responsible for scheduling appointments. Appointments were written in the nurses' Nursing Events Daily Log and then written on a large calendar posted on the inside back of a door in the nurses' station. There was no way to discern if or how appointments were rescheduled. The facility should develop and implement a dental tracking system to ensure that dental appointments were scheduled as recommended, missed and/or refused appointments were rescheduled, and appointments were tracked through to completion. The records were disorganized and fragmented. The individuals' information may be documented in as many as four binders (i.e. Records) under multiple tabs, the Clinical Work Station, and in many various meeting minutes (i.e. Health Status Team Meeting Minutes, Personal Support Planning Meetings Minutes, Human Rights Committee Meeting Minutes, etc.). This causes the facility difficulty in providing integrated services for individuals. The facility does not prepare data summaries for use by the facility related to dental	

#	Provision	Assessment of Status	Compliance
		services and/or quality assurance/enhancements reports, including subsequent corrective action plans.	

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

1. The facility needs to contract with a Registered Dental Hygienist to provide additional training to the nursing staff on oral hygiene.
2. The facility should consider creating a full-time position for a Registered Dental Hygienist to provide oral hygiene and work with the direct care staff to improve their skills in providing oral care.
3. Facility needs to ensure that individuals with chronic oral or dental conditions receive appropriate and timely follow-up care.
4. Facility needs to properly complete the forms currently used to track information regarding dental visits, PSP strategies and Visit Notes. The facility also needs to review and update this tracking form ensuring that it is compliant with all policy and procedures when updated regarding the Settlement Agreement and Health Care Guidelines.
5. The facility needs to better implement strategies (i.e. desensitization programs) to reduce the need for pretreatment sedation as evidenced by the 32 out of 58 (55%) individuals identified in the MR Residents Dental Visits Report receiving pre-treatment sedation.
6. Nurses need to work collaboratively with other relevant PST and HST members to ensure that effective monitoring systems are developed and implemented to monitor individuals who receive pre-treatment sedation for dental/medical treatment as well as for post treatment sedation until the individual is fully recovered.
7. RGSC's Mental Retardation Services Manual, Standard Operating Procedure, MR 300 19: Premedication for Medical and Dental Procedures, Date Established November 2004 needs to be revised and in compliance with the Settlement Agreement and Health Care Guidelines. The facility needs to ensure that data entered on all forms reflects that integrated services are provided to individuals and these services are properly tracked and monitored.
8. RGSC's Mental Retardation Services Manual, Standard Operating Procedure MR 400 07: Invasive Procedures, Date Established, June 2002, Reviewed February 2010 requires that the Consent for Invasive Medical/Dental Procedure be noted in the daily Nursing Report. The nurse responsible for obtaining the Consent for Invasive Medical/Dental Procedure should also document that the signed consent has been received and given to the QMRP in the Integrated Progress Notes so that it becomes a part of the legal record for the individual.
9. The facility should develop and implement integrated tracking systems to ensure and monitor that dental appointments are kept, or appointments missed or refused are rescheduled in a timely manner. The facility also needs systems in place to flag when routine annual appointments and follow-up visits are due.
10. Monitoring systems should be developed and implemented to ensure that dental record management is compliant with generally accepted standards of practice and the requirements of the Settlement Agreement and Health Care Guidelines.
11. The facility should prepare data summaries related to dental services and/or quality assurance/enhancements reports, including subsequent corrective action plans.

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken:** **Documents Reviewed:** 1. Comprehensive record reviews of four individuals (Individual #19, Individual #51, Individual #47, and Individual #101) 2. Partial record reviews of 12 individuals (Individual #94, Individual #10, Individual #96, Individual #60, Individual #15, Individual #140, Individual #79, Individual #113, Individual #55, Individual #85, Individual #36 and Individual #27. 3. Review of requested tour documents including but not limited to: a. AAC evaluations and Speech Assessments b. Speech Policies and Processes **People Interviewed:** 1. Sara Smalley OTR, Habilitation Therapies Coordinator and Occupational Therapist 2. Betty Perez, PNMP Technician 3. Myrna Wolf, QMRP Coordinator 4. Alondra Machado, Quality Administrator 5. 5 direct care staff at 501(2 am and 3 pm) and 4 direct care staff at 502 1 am and 3 pm) **Meetings Attended/Observations:** 1. Observations of 501 and 502 living areas and dining rooms (am and pm) 2. Observed general oral care, positioning, and medication administration on 501 and 502 3. Attended 501 morning unit meeting, HST quarterly, PNMP meeting and 502 shift change
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor Assessment: Currently, RGSC does not have enough clinicians to provide adequate speech therapy to meet the needs of individuals who require these services. RGSC's approach to augmentative communication is virtually non-existent. RGSC lacks sufficient coordination and collaboration between and among the various disciplines, especially to address aspects of communication associated with behaviors. In addition, RGSC fails to provide sufficient assistive communication systems to all individuals who would benefit from such supports. Only individuals who were determined to be completely nonverbal were provided with speech assessments and only 3 individuals have any form of communication support. The majority of individuals including those who are considered to be completely nonverbal are not provided with assessments or supports.

#	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.	There is currently 1 contract Speech Pathologist on staff at RGSC; however it was reported that the Speech Pathologist has not been at RGSC since December and when present is only available on Sundays. Having a Speech Pathologist available on such a limited basis makes it increasingly difficult to provide proactive involvement.	
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.	When present, the Speech assessment contains vague terminology that was difficult to measure. Assessments are narrative in format and do not provide detailed or comprehensive information needed to foster improved communication. For example: • Individual #51 uses facial expressions and hand gestures, but there is no indication within the report that states what these gestures are and the communicative intent. Individuals identified as being nonverbal have received speech assessments but the remaining 52 individuals have not received any form of an assessment. Out of the 18 individuals who are nonverbal, only 3 are provided with any form of support and in most cases these supports were not comprehensive. Individuals who are considered verbal but have markedly decreased communication skills are not provided with assessments or AAC systems to supplement or improve interactions (i.e. Communication dictionaries). There is no collaboration or cohesion between psychology and speech pathology as it relates to behavior support plans and the development of augmentative communication plans. For example: • Individual #51 often approaches people and grabs them in an effort to socialize, however there is no assessment or supports from a communication aspect to address this issue. Per interview with the Habilitation Coordinator and document review, there was no clear policy or process that defines the schedule or criteria regarding whether an individual	

#	Provision	Assessment of Status	Compliance
		receives a speech update or full assessment. In addition, there was no policy in place that defines the frequency in which such assessments would be provided.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	When available, results from the speech assessment are only mentioned in the PSP. Rationales and descriptions of communication interventions regarding use and benefit are not clearly integrated into the PSP. Other than mentioning the device and or assessment, the PSP does not contain information regarding how the individual communicates and strategies that staff may utilize to enhance communication.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	RGSC does have a monitoring form that tracks the presence and working condition of the AAC equipment however the implementation and effectiveness piece is missing. Monitoring should cover all areas in which the use of the device is applicable (which should be all the time). Effectiveness of the device may only be determined by a professional with expertise in that related area; therefore, the implementation of the plans should be followed by the Speech Pathologist. Additionally, the results of the monitors are not collected and utilized to drive future speech interventions. Progress with all communication goals should be consistently reviewed by the Speech Pathologist so that modifications to the plan are timely and appropriate for future language and speech development.	

Recommendations:

1. RGSC and state of Texas should locate a Speech Pathologist as soon as possible so that the needs of the individuals will begin to be met. The Speech language pathologist should be well educated regarding the needs of this population including language and swallowing supports. It is important for all individuals (verbal and nonverbal) be provided with appropriate communications assessments.

2. An increased presence and utilization of communication devices is needed at RGSC. Individuals who are verbal as well as nonverbal should be provided with comprehensive speech assessments. Communication dictionaries should be developed for all individuals to improve communicative interactions and understand between staff and the person. Just because an individual has some verbalizations does not mean that they would not benefit from AAC. AAC can be very effective in supplementing and enhancing existing language.

3. Communication and AAC Assessments should focus on functional communication and address clear areas of need that have been identified through the assessment process of all relevant disciplines (i.e., Psychology).

4. Assessment frequency and depth should be clearly outlined in a policy and followed by the Speech Pathologist. More frequent assessments should be required for those who are receiving services or are in greater need.

5. Communication devices should be present in common areas for use by multiple individuals and staff should be provided with frequent training regarding the benefits of AAC as well as its implementation.

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:** Documents that were reviewed included the annual PSP, PSP updates, SPOs, PBSPs, 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, and behavioral and functional assessments. These documents were reviewed for the following individuals: #1, #11, #27, #36, #48, # 51, #61, #63, #75, #79, #80, #82, #94, #96, #101, #133, #140, and #149. **People Interviewed:** 1. Individual # 27 2. Eric Lopez, Rehabilitation Therapy Technician 3. Arnold Gonzalez, Rehabilitation Therapy Technician 4. One Rehabilitation Therapy Technician 5. James Almendarez, Vocational Service Coordinator 6. Vickie Martinez, PNA at El Paisano 7. One PNA at Vocational Service room 15 8. Myrna Wolf, QMRP Coordinator **Meeting Attended/Observations:** 1. Observed at Vocational Services, rooms 7, 8, 15, shredding, pre-academic area 2. Observed numerous activities at El Paisano and La Paloma
	Summary of Monitor Assessment: Record review, observations and staff interviews reflect a process of teaching that is substantially lacking in the components necessary to produce, maintain or strengthen individual skills. Skill assessments lack the rigor and sophistication to determine the strengths and needs of the individuals living at RGSC with meaningful accuracy or validity. Formal teaching plans do not typically conform to the standards of applied behavior analysis and lack the components necessary to effectively strengthen behaviors. Most training opportunities outside the residences were not directed toward developing skills that would enhance the ability to live in a community setting. Many activities did not train skills that would be needed for community living. Vocational opportunities were limited. Perhaps the area of greatest limitation is the laissez-faire approach to engagement and teaching displayed by numerous personnel at RGSC. The acquisition and maintenance of behavior requires a formal and

	systematic approach. In addition, however, there must also be active engagement of the individuals by those who are responsible for teaching. Many staff members appear to lack the ability to implement teaching programs in a formal and systematic manner. Whether in a formal or informal setting, however, numerous staff also lack the motivation or desire to interact with the individuals living at RGSC in a manner that promotes independence and growth.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	The data below reflect a review of the records of 18 individuals regarding assessment of personal skills and abilities. Substantial limitations were noted across the majority of areas requiring assessments. The lack of adequate behavioral and psychology assessments have been discussed in Section K. Psychiatric assessments are, at best, informal and subjective. Other skill areas are typically assessed via rating scales or other procedures that lack standardization and sophistication. Due to these limitations, although some training programs may reflect needs identified in skill assessments, it cannot be stated unequivocally that the assessments are accurate or have identified real and meaningful needs.	

1		Skill acquisition plans have been implemented to address needs identified in:		0.0%
	a.	Psychological assessment (K 5).		0.0%
	b.	Psychiatric assessment.		0.0%
	c.	Language and communication assessment.		0.0%
	d.	PSP.		0.0%
	e.	Other habilitative, adaptive skill, or similar assessments.		0.0%
	f.	Medical assessments.		0.0%

The data below reflect a review of the records of 18 individuals regarding the structure and content of skill acquisition programs.

2		Skill acquisition plans include components necessary for learning and skill development. At a minimum, these components include the following. (All items below must be FS for this to be scored FS)		0.0%
	a.	Plan reflects development based upon a task analysis.		0.0%
	b.	Behavioral objective(s).		0.0%
	c.	Operational definitions of target behavior.		0.0%
	d.	Description of teaching conditions.		0.0%
	e.	Schedule of implementation comprised of sufficient trials for learning to occur.		0.0%
	f.	Relevant discriminative stimuli.		0.0%

#	Provision	Assessment of Status			Compliance
			b.	Specific instructions.	0.0%
			c.	Opportunity for the target behavior to occur.	0.0%
			d.	Specific consequences for correct response.	0.0%
			e.	Specific consequences for incorrect response.	0.0%
			f.	Plan for maintenance and generalization that includes assessment and measurement methodology.	0.0%

At the time of the site visit, skill acquisition programs seldom included the basic components considered essential to the acquisition and strengthening of behavior. As indicated above, assessments were at best rudimentary. The training programs themselves were typically vague and general, preventing consistent and effective implementation of teaching methodologies. Training sessions as described often included too few trials for learning to take place and lacked consequences likely to enhance the learning process.

It was indicated during the site visit that procedures for task analysis had been revised. This is a very positive step towards enhancing the skill acquisition process. Future reviews will be necessary to determine if revisions to the task analysis procedures are sufficient to improve the quality and outcome of skill acquisitions programs.

3	Overall, the set of skill acquisition programs promote growth, development, and independence	0.0%

Due to the limitations noted in the assessments of skills, the identification of needs and the components of skill acquisition programs, at the time of the site visit it was unlikely that the majority of skill acquisition programs were effectively enhancing the skills and independence of the people living at RGSC.

4	A plan is in place to address, monitor, and maintain reasonable levels of individual engagement in all settings at the facility, including residences, day programs, and work sites.	0.0%

Reviews of the records for 18 individuals, as well as observations of those and other individuals in a variety of settings reflected an overall inability to provide reasonable levels of individualized engagement. In several settings, there was a pervasive lack of engagement.

- Vocational settings and training rooms located in the residences lacked adequate materials and staff offered only minimal interaction.
- In an exercise room, several individuals were observed to be sitting purposelessly or aimlessly wandering with no redirection from the personnel present in the room.
- In one classroom where dietary and nutritional training was to be taking place,

#	Provision	Assessment of Status	Compliance
		individuals were observed to be sitting in front of a television tuned to the Food Network. Although a cooking show was currently on, the individuals present were not attending to the program. • In the same classroom, an individual was being presented a limited selection of plastic food items (including a melon, cheese wheel, and head of cabbage) and asked to indicate to what food group the item belonged. The individual appeared disinterested in the activity and the PNA, when asked, was unable to produce the training program or data collection forms and stated, "Some clients do have data, some don't." Not only are the tasks irrelevant to skills needed to live successfully in community settings (that is, naming the food group for a wheel of cheese is not relevant to preparing food or selecting foods as typically displayed at a grocery store), but there is no formal teaching approach or data to track progress. Furthermore, only one individual in this area has a Specific Program Objective (SPO) for training. • One area did have a functional work activity. In the shredding area, Individual #27 was interviewed. When asked if she likes her job, she stated that she likes to sew. When asked when she sews, she stated, "Weekends." There was no indication that her preferences are considered when identifying functional work activities. • The pre-academic area was vacant at the time of the observation. On the wall were oversized pictures of money. This would indicate the possibility that training in money management does not employ functional objectives and activities, such as use of real money to make change, make purchases, budget, or even practice money exchanges. • Dining rooms consistently lacked meaningful interaction of either an educational or social nature. Individuals were often observed to wander about, engage in self-stimulation, curse, scream, steal food from peers and engage in threats of physical violence. Personnel did not frequently redirect or intervene with these behaviors. When intervention was observed, it was provided in a manner that was inadvertently likely to strength rather than reduce the undesired behavior. For example, undesired behaviors that clearly were exhibited in order to obtain attention typically resulted in increased staff attention, thereby reinforcing or strengthening the undesired form of attention-seeking. The data below reflect a review of the records of 18 individuals regarding application of skill acquisition programs. Based upon these data and the observations noted above, there is little to suggest that the majority of skill acquisition programs or teaching sessions incorporate individual preferences. Furthermore, neither records nor staff interviews revealed any formal preference or reinforcer assessments. Similarly, opportunities for informal development and use of various adaptive skills were seldom made available.	

#	Provision	Assessment of Status			Compliance
		5	There is an adequate array of skill acquisition programs and work and leisure opportunities to:		0.0%
		a.	Incorporate individual preferences; and		0.0%
		b	Support active engagement in the absence of individual skill acquisition plans.		0.0%
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	The data below reflect a review of the records of 18 individuals regarding annual assessments of needs. As indicated previously in this section, while annual assessments are conducted on an annual basis as part of the PSP process, these assessments lack the rigor and sophistication necessary to be considered valid assessments.			
		With regard to living, working and leisure activities, records demonstrate annual assessment of each individual in a minimum of the following areas: (All items below must be FS for this to be scored FS)			0.0%
		a.	Preferences		0.0%
		b.	Strengths		0.0%
		c.	Skills		0.0%
		d.	Needs		0.0%
		e.	Barriers in the community to successful integration		0.0%
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:	RGSC will need to develop procedures to use the information gained from the assessment and review process to develop skill acquisition programs.			
	(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	The data below reflect a review of the records of 18 individuals regarding implementation of skill acquisition programs.			
		Implementation of skill acquisition plans is adequate for skill development and learning:			0.0%
		a	Plan method is implemented as written. (All items below must be FS for this to be scored FS)		0.0%
			As assessed by staff report.		0.0%
			As assessed by observation.		0.0%

#	Provision	Assessment of Status		Compliance	
	needs, and	b.	Plan is implemented according to the specified schedule.		0.0%
		c.	Reinforcement is used appropriately.		0.0%
		d.	Prompting and practice are used appropriately.		0.0%
		e.	Plan is practical and functional in the most integrated setting.		0.0%
		f.	Data are graphed.		0.0%
		g.	The plan is producing meaningful behavior change.		0.0%
		Both observations and interviews with staff reflect that skill acquisition programs are not implemented consistently or as written. Teaching is often conducted in a haphazard manner in terms of schedule and teaching strategy. Cues, prompts and other elements of effective training are often not offered or are presented in an informal and inconsistent manner. No staff members were observed to be collecting data during the implementation of a skill acquisition program and progress notes often reflect that data are missing across several sessions each month. As a result, there is little to suggest that the implementation of skill acquisition programs results in meaningful changes in behavior, independence or the quality of life for individuals living at RGSC.			
	(b) Include to the degree practicable training opportunities in community settings.	There was limited use of community settings for training. Per report from the Vocational Services Coordinator, different groups (usually two groups at a time) go into town to spend their money. No other community training opportunities were described.			

Recommendations:

1. RGSC has developed new formats and tools for assessing skill levels. The facility should be commended for this positive step. It is recommended, however, that quality control systems be established that ensure the new formats achieve the anticipated benefits and are used correctly. Additionally, ongoing review of the findings of these assessments should be conducted to ensure that the assessments are valid and reliable.

2. Staff members tasked with the development of skill enhancement programs at RGSC do not possess an adequate understanding of applied behavior analysis. The facility is recommended to develop and implement a competency-based training curriculum emphasizing applied behavior analysis, learning theory and the development of skill enhancement programs. In addition, the facility should implement routine monitoring of skill acquisition programs, as well as the implementation of those programs.

3. The staff members at RGSC who are responsible for teaching lack the skills to do so effectively. The facility is recommended to develop and implement a competency-based training curriculum for these employees emphasizing the skills necessary in the implementation of training programs. This training should include instruction on the technical aspects of teaching and documentation, as well as the less technical aspects such as building relationships, providing choice, encouraging motivation and making teaching enjoyable.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. RGSC Policy MR 300 20 Most Integrated Setting, dated January, 2010, and all Exhibits 2. RGSC Policy MR 600 01 Person Directed Planning dated July, 2003 3. RGSC Policy MR 600 02 Development and Monitoring of Individual Program Plans, Person Directed Approach, dated September, 1992 4. DADS Policy 018 Most Integrated Setting Practices dated October 30, 2009 5. QSO Scoring Guide Person Directed Planning Process 12/09 6. List of individuals recommended for community placement since July 1, 2009 7. List of individuals who have requested community placement since July 1 , 2009 8. List of individuals transferred to community settings since July 1, 2009 9. List of individuals who have taken group home tours since July 1, 2009 10. PSPs for Individuals #35,55,75, 108, and 122 11. Community Living/Discharge Plan for Individual #135 12. Description provided by DADS of Money Follows the Person (MFP) program status, dated February 5, 2010 13. DSHS Promoting Independence status reports sections on MFP for the first and second quarters of FY 2009 **People Interviewed:** 1. Alma Ortiz, Admissions/Placement Coordinator (APC) 2. James Arnold, Rights Officer 3. Letitia Gonzales, Health Information Management Director, and two department staff **Meeting Attended/Observations:** 1. Meeting with Melanie Peralez,of Tropical Texas Behavioral Health, serving as both contracted and designated Mental Retardation Authority (MRA) for Individual #4. Also participating were Alma Ortiz, APC; Individual #4; Mary Ramos, QM Director; and Rebecca Olivarez, QMRP
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: RGSC has many processes in place to educate individuals and LARs about community living options and to provide opportunities to explore those options. The MRA plays an active role in providing opportunities for individuals to experience community living. At the same time, the PSTs have only identified two individuals for whom the PST recommended movement since July 1, 2009. The processes have not been effective in promoting movement to community living. This would indicate a need to provide more education for staff so that PSTs would have a better understanding of the supports that can be available in community settings. Many LARs also would not support movement. The Facility and MRA offer

	information to LARs; the Facility and MRA need to develop means to encourage LARs to explore community living opportunities The PSTs need to do a more thorough discussion and documentation of the protections, supports, and services each individual needs to move successfully and safely. Development of this list of needs provides the LAR with confidence that a community agency agrees to meet those needs, and it provides the Facility and LAR a checklist to review a possible living arrangement against an individual's needs.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	DADS Policy 108 Most Integrated Setting Practices prescribes "procedures for encouraging and assisting individuals to move to the most integrated setting"; this policy describes the role of the APC and MRA, requirements for informing individuals about community living and for training staff, requires and establishes responsibilities for the Community Living Options Information Process (CLOIP), requires the PST to identify protections, supports, and services that need to be provided to each individual and to identify obstacles to the individual's movement (and requires an annual report of obstacles to be sent to the DADS State Office), and establishes a process to follow if the PST cannot reach consensus regarding a referral for movement to community living. This policy does state that no move will occur if an individual or LAR "has indicated a preference that the person remain at the State Center." The policy requires that the opportunity to participate in community exposure opportunities should continue, and that the individual's and LAR choice be documented as an obstacle. RGSC Policy 600 01 describes the person directed planning process but does not specify the members of the PST. The instructions for Form POR-MR-80.3 Living Options Discussion Record state that the person served, the LAR (if appropriate), and the PST members prepare this form. This implies that the person does not serve as part of the PST itself, which would be inconsistent with the typical descriptions of person directed planning. RGSC Policy MR 600 02 Development and Monitoring of Individual Program Plans, Person Directed Approach states that the individual and LAR, if any, are members of the PST. Since DADS policy 108 describes a process to resolve lack of consensus among the PST, the monitoring team will determine at the first compliance visit whether this process occurs if there is lack of consensus between the individual or LAR and the members of the PST. Texas has received and implemented a Money Follows the Person grant.	

#	Provision	Assessment of Status	Compliance
		During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this policy and its effectiveness in assisting people to move to community living.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	RGSC Policy MR 300 20 Most Integrated Setting, dated January, 2010 implements DADS policy 108. The Facility policy essentially restates the DADS policy but does not provide information on procedures to operationalize that policy. For example, Procedure II.C states, "Active treatment programming to address the identified supports and services should be initiated immediately." The policy does not provide information that may differ across state centers, such as which staff are responsible for the tasks required to initiate the specific active treatment programs for the individual.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The policy requires staff to identify in each individual's PSP the protections, services, and supports needed. Each individual's PSP includes a Living Options Discussion Record. In general, documentation indicates limited discussion of the protections, services, and supports needed. While this is a good start, the discussion needs to be more full and should cover any areas of support that will be needed for successful movement. Some of the language is repeated in each discussion record reviewed, such as follow up by LVN/RN and physician. That may be appropriate, however, for all people who move, and one discussion added a dietitian to this list. Nevertheless, these routine recommendations provided much if not most of the recommended supports. At a minimum, all essential supports and services should be listed in this section of the PSP. The QSO Scoring Guide includes a review of whether the Living Options are identified. Per discussion with Health Information Management staff, the records audit identifies presence or absence of components but not quality of content. • In the PSP for Individual #122, the Living Options Discussion Record records information about preferences for living environment and about services that would be required, including training staff. The services listed did not address some of the individual's behavioral issues that could hinder success in community living. • The Living Options Discussion Record in the PSP for Individual #108 states that the individual's guardian wants her to continue to reside at RGSC. The document notes that the PST continued to discuss living options and services required if an alternative living environment was recommended but listed only one. The document also states, the team asked Individual #108 where the individual would like to live.	

#	Provision	Assessment of Status	Compliance
		According to the document, Individual #108 "wants to live" (sic) but did not complete the sentence to say where . • The Living Options Discussion Record in the PSP for Individual #55 describes a significant barrier to moving to community living but does not describe fully the services and supports the individual would need. • The Living Options Discussion Record in the PSP for Individual #75 also does not have a full discussion of services and supports needed that covers issues discussed in other parts of the PSP. • The Living Options Discussion Record in the PSP for Individual #35 included documentation of visits the individual has made to providers. The individual was reported to have expressed a preference to continue to live at RGSC. A plan to schedule additional visits was documented. There was documentation of a limited but not full discussion of services and supports needed; this is found only in this discussion and is not included in any action plans or other part of the PSP. Significant needs identified in other areas of the PSP should be addressed if they lead to a need for specific supports. Furthermore, plans for actions documented in the Living Options Discussion Record should become part of the PSP and should indicate who will be responsible for what actions.	
	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.	The MRA stated that all individuals are provided the opportunity to visit community residences. If an individual or LAR declines, the opportunity is presented at least annually. This was supported by the documentation of Living Options discussions for Individuals #35 and #108. Further review of activities will be done at the first compliance visit. Individual #4 returned from a 10-day visit to a facility. She stated that she did not want to move there. The MRA asked if she would be willing to visit someplace else. She indicated she would. It is remarkable that the MRA and Facility would provide the opportunity for a trial visit lasting a full 10 days. The Facility demonstrated a willingness to support the choice of the individual.	
	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	Documentation in PSPs for five individuals indicates that review is done by the PST annually.	

#	Prov	Assessment of Status	Compliance
	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.		
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:	Because no person was identified who has been accepted for and agreed to movement, this was not reviewed during the baseline visit. Living Options Discussion Records uniformly note the need for visits and for training staff of the facility/agency that will provide supports and services.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.		
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.		
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the		

#	Provi	Assessment of Status	Compliance
	supports and services to be provided at the new setting.		
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.	Because only one person had moved since July 1, 2009, this was not reviewed.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	Because the most recent move occurred in October, 2009, no visit was possible to review this.	
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.	DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices, October 30, 2009 requires that "an assessment will be conducted to identify the effectiveness of the living option process. A ten percent (10%) random sample will be conducted monthly to evaluate policies, procedures and practices related to the transition/discharge process." This policy does not provide further detail as to how this evaluation will be conducted. RGSC Policy MR 300 20 Most Integrated Setting establishes procedures for the CDLP and has, as an attachment, a post-move monitoring checklist, but it does not identify a process for quality assurance. Because this policy is dated January, 2010, and there have been no moves since then, quality assurance for CDLP was not reviewed. The Facility should establish a procedure for quality assurance and refer to it in policy.	
T1g	Each Facility shall gather and	This information will be reviewed at compliance visits.	

#	Provision	Assessment of Status	Compliance
	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.		
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed	The Facility has identified two individuals for whom the PST recommended movement since July 1, 2009; one of those has moved. In addition, the Facility identified two people who have requested movement.	

#	Provision	Assessment of Status	Compliance
	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 standard assessment tool, consistent with the sample tool attached at Appendix C. Should the	Because the most recent move occurred in October, 2009, no visit was possible to review the timeliness and effectiveness of post-move monitoring visits. A standard post-move monitoring checklist is included as an attachment to RGSC Policy MR 300 20 Most Integrated Setting.	

#	Provision	Assessment of Status	Compliance
	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.		
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	Because no individual had moved in the prior 90 days, no post-move monitoring visits were scheduled during the review.	
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.	Only one individual at RGSC would meet this standard, and no move is planned at this time.	
T4	**Alternate Discharges -**		

#	Provision	Assessment of Status	Compliance
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	RGSC Policy MR 300 20 Most Integrated Setting requires the Facility to comply with CMS-required discharge planning for the individuals meeting the definitions of this provision.	

Recommendations:

1. RGSC should ensure that full discussion of living options is held during the PSP meeting or at other times and that essential supports and services needed are documented in the Living Options Discussion Record.
2. The Facility should establish a procedure for quality assurance and refer to it in policy.

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Rio Grande SOP MR 200 04: Process for Reviewing the Need for Guardianship (March, 1999) 2. Texas Probate Code Chapter XIII. Guardianship 3. Texas Administrative Code Title 40, Part 1, Chapter 4, Subchapter C 4. List of individuals with Guardian Need for February 2, 2010 5. List of guardianships established since 7/1/09 6. Guardianship Contact Report from James Arnold, Patient Rights Officer, November, 2009-February, 2010 7. Copy of email of December 21, 2009 from James Arnold to Mary Ramos documenting efforts to recruit guardians 8. Guardianship Tracking System blank form 9. Form letter used by James Arnold to recruit guardians, dated 2/3/10 10. Advocacy, Incorporated Handout Materials CS5-Guardianship for Texans with Disabilities 11. Several consent forms used by RGSC 12. Sheet titled Training for Ranking Need for Guardian 13. Minutes of Human Rights Committee meetings of July 2, 9, 18, and 23, 2009 and March 4, 2010 14. PSPs for Individuals #108 and #122 **People Interviewed:** 1. James Arnold, Rights Officer 2. Participants in Advocacy Council meeting of March 4, 2010 **Meeting Attended/Observations:** 1. Rio Grande State Center Advocacy Council, March 4, 2010
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: RGSC has developed a prioritized list of individuals lacking capacity. The list includes people with and without LARs . Facility policy requires review of need for LAR annually but does not indicate a timeline to update the prioritized list. There is an example in which the PSP statement of availability of a LAR may not match the list. The Facility does take action to recruit guardians. However, no new guardians have been appointed since July 1, 2009. This indicates that there is a need for more focused and intensive efforts.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and	Rio Grande State Center Standard Operating Procedure MR 200 04 dated March, 1999, requires at least annual review of need for guardianship at the annual staffing. It does not require semiannual updating, nor does it establish criteria or guidance for such decisions.	

#	Provision	Assessment of Status	Compliance
	update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The Facility has a list titled Guardian Need that lists each individual. There is a brief report that gives information relevant to the rating for each person. According to the document "Training for Ranking Need for Guardian," ratings were done by a review group consisting of James Arnold, Myrna Wolfe (listed as QMRP Coordinator), and Mary Reyes (listed as La Paloma Shift Supervisor). No date for the ranking was provided. No information was gathered as to how this interfaces with or supersedes the review required in the Standard Operating Procedure. However, this type of independent review provides the possibility of a good peer review process. The facility should update the Standard Operating Procedure to require semiannual update of the list and should, when doing so, consider having both the annual review by the PST and a peer review process by an independent panel. On the list as of February 2, 2010, eight people are listed as having a critical need for a guardian, 11 as having a high need, 13 as having a medium need, and 19 as having a low need. Twenty people have a level of need listed as "n/a"; of those, 14 have a guardian, it is unclear for 4 whether they have a guardian, and 2 are identified as in need of a guardian in spite of the "n/a" rating. Individual #33 is listed as having a low need, but the brief report indicates his father is his guardian; Individual #5 was listed as having a low need, but the brief report listed is sister as guardian. The rating list provides a good informational tool. During the initial compliance review, evaluation will be done of the relationship of ratings to the criteria listed on the document "Training for Ranking Need for Guardian." Reviews of PSP for Individual #108 indicates that she does not have an LAR and is not able to provide informed consent in a number of areas; the Guardianship Need list indicates a guardian was "initially named" but is unclear on whether the guardianship continues. For individual #122, both the PSP and Guardian Need list state there is an LAR. At the Human Rights Committee (HRC) meeting of March 4, 2010, there was discussion of rights assessments for Individuals #8 and #62, both adults without guardian. Minutes of the meeting state that neither person is capable of giving consent, although Individual #8 has not been ruled incompetent. Minutes do not indicate who will provide consent. At the HRC meeting of July 16, 2009, Individual #33 was listed as having no guardian. The list of guardianships established since July 1, 2009 does not include this individual. All other identification of guardian status in the reviewed HRC minutes matched the Guardian Need list.	

#	Provision	Assessment of Status	Compliance
		RGSC does not consider a person to be LAR if letters of guardianship "have lapsed" or are "out of date" (as noted, for example, in the Guardian Need list brief report for Individual #66). Probate Code Chapter XIII, Sec. 672 states that a court "may review annually" whether guardianship needs to continue. RGSC should review to determine whether LAR authority may continue without annual review and therefore prevent lapses in LAR involvement in consent for restrictions of rights.	
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 did not report any new guardianships occurring since July 1, 2009, although one guardianship was renewed May 14, 2009. However, the Guardianship Contact Report lists a number of contacts and activities intended to seek guardians. The number of contacts reported was limited to families of two individuals, contacts asking two other people if they would be interested in serving as guardian for people living at RGSC, and a presentation at the Parents Meeting (which was clarified in the email from James Arnold to Mary Ramos as actually being a church meeting). At that meeting, a letter was read and passed out requesting volunteers to serve as guardians; also, the Advocacy, Inc., Guardianship pamphlet was distributed.	

Recommendations:

1. The facility should update the Standard Operating Procedure to require semiannual update of guardianship need list and should, when doing so, consider having both the semiannual review by the PST and a peer review process by an independent panel.
2. RGSC should work with DADS to identify new procedures that might prevent lapses in LAR involvement in consent for restrictions of rights.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** (In addition to the documents noted below, all team members provided information about the status of records; please note records identified in sections above.) 1. DADS Recordkeeping Policy #020 dated 9/28/09 2. RGSC Standard Operating Procedure (SOP) HIM 400-07 Basic Documentation Guidelines, dated September 7, 1992 3. RGSC Standard Operating Procedure (SOP) HIM 400-04 Storage of Medical Records, dated August 5, 1992 4. RGSC Standard Operating Procedure (SOP) HIM 400-14 Filing and Purging of Information-(MR Medical Records), dated January 5, 1996 5. RGSC Standard Operating Procedure (SOP) HIM 500-06 Accessibility of Records by Authorized Staff, dated March 1, 1993 6. RGSC Standard Operating Procedure (SOP) HIM 400-26 Falsification of Records, dated December 22, 2009 7. RGSC Standard Operating Procedure (SOP) HIM 400-20 Reporting Percentage of Delinquent Medical Records (MR), dated March 1, 2000 8. MR Index, Chart 1, Chart 2, and Chart 3 9. MR Delinquency Record Review Audit Tool 10. MR Delinquency Reports of September, 2009 through January, 2010 11. DADS QSO Scoring Guide 12. Complete Active Records for Individuals #4, 27, 108, and 145 13. Partial records for Individuals #8, 39, 47, 51, and 101 14. PSPs for Individuals #35, 55, 75, and 122 15. ME Books for Individuals #4 and 19 **People Interviewed:** 1. Letitia Gonzales, Health Information Management Director; Angie Alejo, MR Medical Records Supervisor; and Melissa Canales, Unified Records Coordinator **Meeting Attended/Observations:** 1. Presentation on March 1, 2010 about records system by Angie Alejo, MR Medical Records Supervisor; Melissa Canales, Unified Records Coordinator; and Letitia Gonzales, Health Information Management Director 2. Several observation by multiple monitoring team members at 501 and 502 living areas on all three shifts
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.

	Summary of Monitor's Assessment: RGSC has made the initial steps toward development of an electronic record system. Transition from written records to electronic records must be done carefully to ensure information is available as needed and that the system encourages integrated review and planning across disciplines. Current records are voluminous. Some documents are placed inconsistently in different locations in different individual records. Some current records are located deep within the record whereas old assessments are in the front. Information from the records is not consistently used during the person directed planning process. As DADS record-keeping policy is revised, the RGSC SOPs will need to be reviewed and revised to be consistent with DADS policy. It is unclear when SOPs have been revised. Audits of records focus on whether content is present or absent but do not include audit of quality of content.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	DADS policy 020 is recent. RGSC has tagged its SOPs to the DADS policy in order to operationalize it. Each SOP has a next review date but does not have a last review date, so it is not possible to determine whether it has been revised to implement the DADS policy. The Facility has made the initial steps toward establishment of an electronic record. Currently, progress notes are written by Nursing and Dietary departments in the Clinical Work Station (CWS). Additional departments are to be added. This process had begun, stopped, and then restarted within the month before the visit. There were times when the nursing integrated progress notes were entered only into the CWS system, and other times when the integrated progress notes were only written in the record. Changeover from a paper system to an electronic system is a difficult process; care must be taken to ensure all necessary records are available and accessible so that treatment and care decisions can be timely and based on accurate information. The Facility has ensured that enough computers are available for use of this system. Computers are currently in rooms, a situation which is acceptable for current purposes but may become problematic if and when PNAs begin to enter information, as they would not be available to monitor individuals. Currently, records are voluminous, with many requiring four large notebooks. The first book includes a range of information including the PSP and program information as well as consents. The second book consists primarily of medical information including the continuous medical record. The third and fourth books include medical and psychiatric assessments and, along with the CWS, progress notes. Because it is printed from the	

#	Provision	Assessment of Status	Compliance
		CWS, each note is a separate page. Although the continuous medical record does not have gaps and spaces, many of the progress notes have large blank areas at the bottom without any cross-through, as noted for example in the record for Individual #27. When the monitoring team asked for the integrated progress notes on individual #108 for the last three months, the QA Nurse stated they would have to be printed from CWS. When they were printed, it resulted in approximately one and one-forth inch stack of paper with one single entry by nursing on each sheet of paper. Records were not well organized. Some items are placed inconsistently in the records. For example, OT/PT assessment is located under the "staffing tab" in one chart, the "adjunctive tab" in another chart and per report, under the therapy tab in others. At times, the OT/PT assessment was able to be located however this was not consistent across the sample. At times, the same assessment or report is available in three different locations within the chart thus making the chart confusing and less user-friendly due to the inconsistencies. In the record for Individual #108, the current annual psychological assessment is placed in the Psychological/Psychiatric section of Chart 3, but an old psychological assessment is at the beginning of Chart 1. For Individual #27, the continuous medical record notes in Chart 2 begin 12/1/83 and end 10/2/02; there was no statement directing where to find current notes. Annual Nursing Assessments were kept in the Program Record, while the Nursing Quarterly Assessments were in the Medical record. Nursing Care Plans were often missing for the records and kept in the nurses' binders. Records were legible and in chronological order. SOPs describe and require the active record and overflow record. The ME book serves as the individual notebook. ME books are available and accompany the individual. Observations by monitoring team members indicate use of ME books to direct PNA action is inconsistent.	
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	Because SOPs have only an implementation date and a next review date, it is not possible to identify whether they have been revised. Date of most recent revision should be included on all policies and SOPs. Fourteen of the Nursing SOPs were dated as being reviewed/revised March 2010. SOPs NR200-97 and NR200-98 had not been updated since 1992. It is questionable how these policies and procedures could have been thoroughly and adequately reviewed and revised in March 2010, since the SA monitors were at the facility during the week of March 1, through March 5, 2010.	

#	Provision	Assessment of Status	Compliance
	this Agreement.		
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.	The HIM Director reports that records are audited the month following all staffings, so that some months include more than five audits; if there are fewer than five staffing in a month, the plan is to audit a record from a staffing scheduled for the next month. Monthly MR Delinquency reports show eight audits in September, 2009, five in October, six in November, nine in December, and eight in January, 2010. Per interview with HIM Director and staff, the reports are reviewed monthly, but not trend data are tracked. It is very difficult to look at monthly reports and identify trends. It would be an easy matter to prepare graphs or charts that would make trends more evident. Audits are done using the MR Delinquency Record Review Audit Tool. Per discussion with Health Information Management staff, the records audit identifies presence or absence of components but not quality of content. DADS implemented the QSO Scoring Guide for the Person Directed Planning Process, revised in December, 2009. Although that scoring guide focuses on the person directed planning process and the PSP, much of the scoring may provide guidance for evaluating quality of content of the record. The Facility should review the relationship between the MR Delinquency Record Review Audit Tool and the QSO and should integrate aspects of both into a more effective audit process.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	Use of records for care and treatment decisions will be reviewed at all compliance visits. During the PSP for Individual #108, there was little presentation of data or reference to information from the record.	

Recommendations:

1. When bringing additional department into the CWS system, RGSC should develop a process that will encourage interdisciplinary review and planning for individuals, including ensuring entries are easily accessible to all staff providing services and supports to an individual.
2. The Facility should review the relationship between the MR Delinquency Record Review Audit Tool and the QSO and should integrate aspects of both into a more effective audit process.
3. Date of most recent revision should be included on all policies and SOPs.
4. Ensure that data are gathered on reviews of records to identify trends and to plan corrective actions.
5. Develop a plan to ensure that discussion of information from records, including data, during meetings is used to influence decisions.

Health Care Guidelines

SECTION I: Documentation	
	Steps Taken to Assess Compliance: Health-related records were reviewed for Individuals #8, #10, #15,#19, #27, #36, #39, #47, #51, #55, #60, #79, #85, #94#101, #108, 113. and #140.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The records were extremely disorganized. Some of the documentation was contained in the CWS computerized system and some were in the records. There were times when the nursing integrated progress notes were entered only into the CWS system, and other times when the integrated progress notes were only written in the record. There current procedure is to enter the integrated progress notes into the CWS system. Nursing Care Plans were often missing for the records and kept in the nurses' binders. When the monitoring team asked for the integrated progress notes on individual #108 for the last three months, the QA Nurse stated they would have to be printed from CWS. When they were printed, it resulted in approximately one and one-forth inch stack of paper with one single entry by nursing on each sheet of paper. Annual Nursing Assessments were kept in the Program Record, while the Nursing Quarterly Assessments were in the Medical record. Reviewing integrated progress notes and other related nursing documentation was difficult to locate for review in the facility's record keeping system and was not conducive to completing meaningful record reviews

Recommendations:

1. When bringing additional department into the CWS system, RGSC should develop a process that will encourage interdisciplinary review and planning for individuals, including ensuring entries are easily accessible to all staff providing services and supports to an individual.
2. The facility's record keeping system needs to be organized and conveniently located for review.

SECTION II: Seizure Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Reviewed RGSC's Nursing Manual: SOP NR100-13, Seizure Management, Date Established: August, 1987, Reviewed/Revised: March 2010. 2. Reviewed partial records including seizure records for Individuals #39 and #19 3. Interviewed the following: a. Yolanda Gonzalez, RN, Chief Executive Nurse b. Marcy Valdez, RN, Nurse Manager c. Jessica Juarez, RN, Quality Assurance Nurse

	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: RGSC's Nursing Manual: SOP NR100-13, Seizure Management, Date Established: August, 1987, Reviewed/Revised: March 2010, although reviewed and updated during the week of March 1 through 5, 2010, it was not in alignment with the SA and HCG. The policy was not comprehensive. It was limited to nursing responsibilities and failed to include medical responsibilities. The Seizure Record included the following information: 1. Chronology (time started, time ended and duration), 2. Check spaces for describing all appropriate conditions observed, 3. Blank spaces to record medication administered, and 4. Blank space to record signature and title. Even though the form provided space for detail documentation it was not completed properly and typically noted detailed documentation in the Progress Notes". The QA Nurse reported that direct care staff did not complete the Seizure Record. They report their observations to the nurse who records the information. When asked the reasons for this procedure she stated she did not know why the nurses completed the form as opposed to the direct care staff. According to professional standards of care the staff observing the seizure episode records their observations and actions taken on the Seizure Record. Review of the completed Seizure Records for individuals #39 and #19, indicated that they were poorly completed, e.g., timing of the seizures were not consistently completed, descriptions of the seizure typically only included that the individuals had a blank stare and/or twitching of eyelids or "no description given", and the signatures and titles of the nurses completing the record were missing. The records reviewed failed to describe nursing' assessments or interventions. The seizures were not graded and there was no place on the record for physician's review and signature. While the integrated progress notes may contain more detailed information regarding seizure episodes, it is doubtful from the limited or missing information contained in Seizure Records, that any substantive information would have been documented in the integrated progress notes. The facility needs to cross-walk their Seizure Policy with the SA and HCG to ensure compliance. The Seizure Record needs to be revised to include additional information regarding observations, assessments, interventions, grading of seizure type, and physician's review and signature. The facility needs to ensure that staff observing seizure activity are re-trained in Seizure Management. The facility needs to ensure that seizure activity is recorded by the staff observing the event. This issue will be reviewed in more depth at the next tour.

Recommendations: 1. The facility needs to cross-walk their Seizure Policy with the SA and HCG to ensure compliance. 2. The Seizure Record needs to be revised to include additional information regarding observations, assessments, interventions, grading of seizure type, and physician's review and signature. 3. The facility needs to ensure that staff observing seizure episodes are re-trained in Seizure Management. 4. The facility needs to ensure that seizure activity is recorded by the staff observing the event.	**Recommenda**

SECTION III: Psychotropics/Positive Behavior Support	
	Steps Taken to Assess Compliance: Reviewed: 1. RGSC's Nursing Manual: SOP NR200-103, MOSES – Monitoring of Side Effects, Date Established: November, 2009 2. RGSC's Nursing Manual: SOP NR200-104, DICUS – Monitoring of Medication Side Effects and Tardive Dyskinesia,, Date Established: November, 2009 3. Partial Records for Individuals #47, #108, #51, #39, #8, and #101
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: RGSC's nursing staff completed the DISCUS every three months and MOSES every six months. The assessment of these two items was not summarized on the Nursing Annual and/or Quarterly Assessments indicating individuals' therapeutic response to psychoactive medications. The facility nurses did not participate in the quarterly PBST reviews to collaborate with other PBST members in assessing, planning, implementing and evaluating programs and other activities that impacted the individual's behavior. The nurses did not develop a NCP and/or HMP with individualized goals and interventions to meet the individual's needs. The HMP needs to include interventions for specific side effect monitoring by the staff and reference to behavioral interventions outlined in the Behavior Plan.

Recommendations:

1. The facility's nursing staff needs to participate in assessing, planning, implementing and evaluating programs and other activities that impact upon the individual's behavior.
2. The facility's nursing staff needs to summarize individuals' therapeutic response to psychoactive medications on the Nursing Annual and/or Quarterly Assessments.

SECTION IV: Management of Acute Illness and Injury	
	Steps Taken to Assess Compliance: Records reviewed for Individuals #8, 47, 51, 101, and 108
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Although not reviewed during this baseline visit, the use of agency staff and lack of competency-based training for nurses on in many of the diagnoses or conditions associated with individuals with intellectual and developmental disabilities and physical and nutritional management along with minimal use of

	augmentative communication, it is possible that acute illnesses and perhaps injuries are not identified immediately.

Recommendations: There are no additional recommendations at this time.

SECTION V: Prevention	
	Steps Taken to Assess Compliance: Reviewed; 1. Comprehensive records of four individuals (Individual #19, Individual #51, Individual #47, and Individual #101) 2. Partial records of 15 individuals (Individual #8, #10, #15, #27, #36, #39, #51, #55, #60, #79, #85, #94, #96, #113, and #140
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Definitions of risk level and frequency of assessment for individuals at moderate risk may not be adequate to prevent avoidable health conditions. There is not adequate availability of wellness activities in the community or at the Facility to serve a role in prevention of adverse health conditions.

Recommendations: There are no additional recommendations at this time.

SECTION VI: Nutritional Management Planning	
	Steps Taken to Assess Compliance: Please see sections above that address section O of Settlement Agreement for further information.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Please see sections above that address section O of Settlement Agreement for further information.

Recommendations:
There are no additional recommendations at this time.

SECTION VII: Management of Chronic Conditions	
	Steps Taken to Assess Compliance: Health-related records were reviewed for Individuals #8, #10, #15,#19, #27, #36, #39, #47, #51, #55, #60, #79, #85, #94#101, #108, 113. and #140.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Please reference Sections M, O, and P above.

Recommendations:
There are no additional recommendations at this time.

SECTION VIII: Physical Management	
	Steps Taken to Assess Compliance: Please refer to sections above that address section O and P of Settlement Agreement for additional information.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Please see sections above that address section O and P of Settlement Agreement for further information

Recommendations:
There are no additional recommendations at this time.

SECTION IX: Pain Management	
	Steps Taken to Assess Compliance:
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.

	Summary of Monitor's Assessment: This will be reviewed at the first compliance visit..

Recommendations: There are no additional recommendations at this time.

List of Acronyms Used in This Report
Rio Grande State Center
March, 2010 Baseline Tour

Acronym	Meaning
AIMS	Abnormal Involuntary Movement Scale
A/N/E	Abuse/Neglect/Exploitation
APC	Admissions/Placement Coordinator
BCBA	Board Certified Behavior Analyst
B/P	Blood Pressure
BSP	Behavior Support Plan
CAP	Corrective Action Plan
CLDP	Community Living Discharge Plan
CWS	Clinical Work Station
CLOIP	Community Living Options Information Process
CEN	Certified Executive Nurse
CPR	Cardiopulmonary Resuscitation
DADS	Texas Department of Aging and Disability Services
PNA	Direct Care Professional/Psychiatric Nurse Assistant/direct care staff
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DOJ	United States Department of Justice
DSM	Diagnostic and Statistical Manual of the American Psychiatric Association
DUE	Drug Utilization Evaluation
EKG	Electrocardiogram
ELMO	Employee Health Program, Employee Health Medical Records Policy and Procedure
FA	Functional Analysis of behavior or Functional Assessment

HCG	Health Care Guidelines
HIM	Health Information Management
HMP	Health Maintenance Plan
HRC	Human rights committee
HST	Health Status Team
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IDT	Interdisciplinary Team
IMC	Incident Management Coordinator
ISP	Individual Support Plan
LAR	Legally Authorized Representative
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MD/M.D.	Medical Doctor
MI	Mental Illness
MOSES	Monitoring of Side Effects Scale
MR	Mental Retardation
MRA	Mental Retardation Authority
NCP	Nursing Care Plan
MDRO	Multi-Drug Resistance Organism
MRSA	Multi-drug Resistant Staphylococcus Aureus
NP	Nurse Practitioner
OIG	Office of the Inspector General
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
PALS	Positive Adaptive Living Survey
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PIC	Performance Improvement Council
PMAB	Physical Management of Aggressive Behavior
PNA	Psychiatric Nurse Assistant/direct care staff
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
POI	Plan of Improvement
PRN	Pro Re Nata (as needed)
PSP	Personal Support Plan

PT	Physical Therapy/Physical Therapist
PTR	Psychiatric Treatment Review
QA	Quality Assurance
QE	Quality Enhancement
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietitian
RGSC	Rio Grande State Center
RN	Registered Nurse
r/o	Rule out
SA	Settlement Agreement
SAM	Self□Administration of Medication
SIB	Self□injurious Behavior
SLP	Speech and Language Pathologist
SOP	Standard Operating Procedure
SPO	Specific Program Objective
SSLC	State Supported Living Center
STD	Sexually Transmitted Disease
STHCS	South Texas Health Care System
TB	Tuberculosis